

11552

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>3704 Farragut ST.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens SAN.</u>		e. STREET ADDRESS <u>Kensington Md.</u>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>J.</u> Last <u>Aebersold</u>		4. DATE OF DEATH Month <u>10</u> Day <u>20</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1881 - 3/12</u> yrs.
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>8</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>D.C. TRANSIT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Motorman</u>	
11. BIRTHPLACE (State or foreign country) <u>SWITZERLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Rudolph Aebersold</u>		14. MOTHER'S MAIDEN NAME <u>MARIE WEBER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>578-10-6619A</u>	
17. INFORMANT <u>Robert Aebersold, Son-same 2d</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO <u>Chronic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senility</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>yes</u> <u>yes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>(6/11/55)</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1955</u> to <u>10/20</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>10/20</u> , 19 <u>60</u> , and that death occurred at <u>1:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Sam Allen</u>		ADDRESS (Street, city or town, state) <u>Kensington, Md.</u> DATE SIGNED <u>10/20/60</u>	
PHYSICIAN'S NAME (Type) <u>Samuel Allen, M.D.</u>		<u>Kensington, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/22/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumfrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>Arthur L. Hume</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	
DATE <u>OCT 24 '60</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be filed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11-182

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

CERTIFICATE OF DEATH

11-182

Blank lines for text entry.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

FOR STATE
HEALTH DEPT.

(M)

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11502 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11483											
1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN 1b 4 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 9029 FAIR VIEW ROAD				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 9029 FAIR VIEW ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) GEORGE J. AITKEN				4. DATE OF DEATH OCT. 7 19 60							
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/12/07		9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Deputy Controller				10b. KIND OF BUSINESS OR INDUSTRY ICA		11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George Joseph Aitken				14. MOTHER'S MAIDEN NAME Elizabeth McQuistan							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 129-30-8685		17. INFORMANT Mrs. Helen D. Aitken, 9029 Fair View Rd. Address Silver Spring, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) History of previous coronary disease 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Frank J. Broschart EXAMINER'S NAME (Type) FRANK J. BROSCART				CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 10/7/60							
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL 10/9/60				22b. DATE THEREOF 10/9/60		22c. NAME OF CEMETERY OR CREMATORY MT. OLIVE CEMETERY		22d. LOCATION (City, town, or country) (State) ZANESVILLE, OHIO			
23. FUNERAL DIRECTOR WARNER E. PUMPHREY, INC. Raymond E. Jiska				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR OCT 11 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

11523

RECEIVED BY THE OFFICE OF THE SECRETARY OF THE ARMY

11501

11501

TO THE SECRETARY OF THE ARMY
FROM THE SECRETARY OF THE ARMY
SUBJECT: [illegible]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11561

11484

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 9 hrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS 15510 Georgia Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First (Twin "A") Middle ALDERTON Last ALDERTON				4. DATE OF DEATH Month October Day 19 Year 1960			
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-18-60		9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Phillip Frederick ALDERTON				14. MOTHER'S MAIDEN NAME Judith Ann DICKIE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (F) Phillip F. Alderton, same as #2 above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 776 X IMMEDIATE CAUSE (a) Prematurity (twin gestation at 26 weeks) DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH 9 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (physician) attended the deceased from Oct. 18 1960 to Oct. 19 1960 , that (I) lost saw the deceased alive on Oct. 19 1960 , and that death occurred at 8:28am M, from the causes and on the date stated above.							
22a. SIGNATURE Lawrence G. Thorne				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-19-60	
22c. PHYSICIAN'S NAME (Type) Lawrence G. THORNE, LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-24-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey Funeral Home, Bethesda, Md.				25a. REC'D BY REGISTRAR OCT 24 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Thorne	

2151182XVO

1111

STATE OF OHIO

1111

IN SENATE, January 12, 1911.

REPORT OF THE

COMMISSIONERS OF THE LAND OFFICE

FOR THE YEAR 1910.

RECEIVED JAN 13 1911

BY THE CLERK OF THE SENATE

AND BY THE CLERK OF THE HOUSE

OF REPRESENTATIVES

Handwritten signature and text:
J. M. [illegible]
[illegible]

RECEIVED JAN 13 1911
BY THE CLERK OF THE SENATE

AND BY THE CLERK OF THE HOUSE
OF REPRESENTATIVES

RECEIVED JAN 13 1911

BY THE CLERK OF THE SENATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
11562
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11485

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 7hrs.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		d. STREET ADDRESS 15510 Georgia Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) (Twin "B")		First ALDERTON		Middle ALDERTON		Last ALDERTON		4. DATE OF DEATH Month October		Day 19		Year 1960			
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-18-60		9. AGE (In years last birthday) yrs. 7		IF UNDER 1 YEAR Months 28		IF UNDER 24 HRS. Hours 28		Min. 28	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) - - - - -		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME Phillip Frederick ALDERTON		14. MOTHER'S MAIDEN NAME Judith Ann DICKIE													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT (F) Phillip F. Alderton, same as #2 above		Address (F) Phillip F. Alderton, same as #2 above									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity (twin gestation at 26 weeks) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 771X DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 7 hours													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that (I) physician attended the deceased from Oct. 18 6:48am to Oct. 19 1960 , that (I) yes lost saw the deceased alive on Oct. 19 1960 , and that death occurred at M , from the causes and on the date stated above.															
22a. SIGNATURE Lawrence G. Thorne		M.D. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-19-60							
22c. PHYSICIAN'S NAME (Type) Lawrence G. THORNE, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-24-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) Arlington		(State) Virginia							
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey		ADDRESS R. A. Pumphrey Funeral Home, Bethesda, Md.		25a. REC'D BY REGISTRAR DATE OCT 24 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus									

2251183XV0

11882

11882

11882

11882

11882

11882

11882

11882

11882

11882

11882

11882

11882

11882

11882

11882

11882

11882

11882

11882

11882

11882

11882

11882

11882

11882

11882

11882

11882

11882

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

Dr Brochart Notified

11563										11486																													
1. PLACE OF DEATH										2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)																													
a. COUNTY					b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					a. STATE					b. COUNTY																								
MONTGOMERY					BETHESDA					MARYLAND					MARYLAND																								
c. LENGTH OF STAY IN 1b					d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					d. STREET ADDRESS																								
D.O.A.					SUBURBAN HOSPITAL					43 KENSINGTON					10610 Parkwood Drive																								
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																							
3. NAME OF DECEASED (Type or print)										4. DATE OF DEATH																													
First Middle Last										Month Day Year																													
EDITH ANDERSON										OCTOBER 31 19 60																													
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.																											
Female		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11/4/91		68		Months Days Hours Min.																													
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)										10b. KIND OF BUSINESS OR INDUSTRY										11. BIRTHPLACE (State or foreign country)										12. CITIZEN OF WHAT COUNTRY?									
CHANCELLOR - RETIRED																				Minn.										U.S.A.									
13. FATHER'S NAME										14. MOTHER'S MAIDEN NAME																													
David Anderson										Amanda Johnson																													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)										16. SOCIAL SECURITY NO.										17. INFORMANT																			
No																				Mrs. E. Andahl (Moline, Ill.) (Sister)																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																				INTERVAL BETWEEN ONSET AND DEATH																			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										Infection, Small Intestine										48 hrs.																			
DUE TO										Valvulus										48 hrs.																			
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.										DUE TO										Surgical adhesions (more than 4 yrs)																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																													
20c. TIME OF INJURY Month, Day, Year										20d. INJURY OCCURRED										20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town) (County) (State)									
Hour a. m. p. m.										While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>																													
21. I certify that (I) (this hospital) attended the deceased from Oct 30, 1960 to Oct 31, 1960 that (I) (we) last saw the deceased alive on Oct 30, 1960, and that death occurred at 5:00 PM from the causes and on the date stated above.																																							
22a. SIGNATURE										22b. ADDRESS										22c. PHYSICIAN'S NAME (Type)										22d. ADDRESS									
Robert T. Thibadeau										10609 Concord Kensington, Md																													
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE THEREOF										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City, town, or county) (State)									
Removal										11-2-1960										Riverside Cemetery										Moline, Ill.									
24. FUNERAL DIRECTOR'S SIGNATURE										ADDRESS										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE									
Joseph Gustafson										1756 Palms NW										DATE NOV 3 '60										Arthur L. Kraus									

1188

RECEIVED

1188

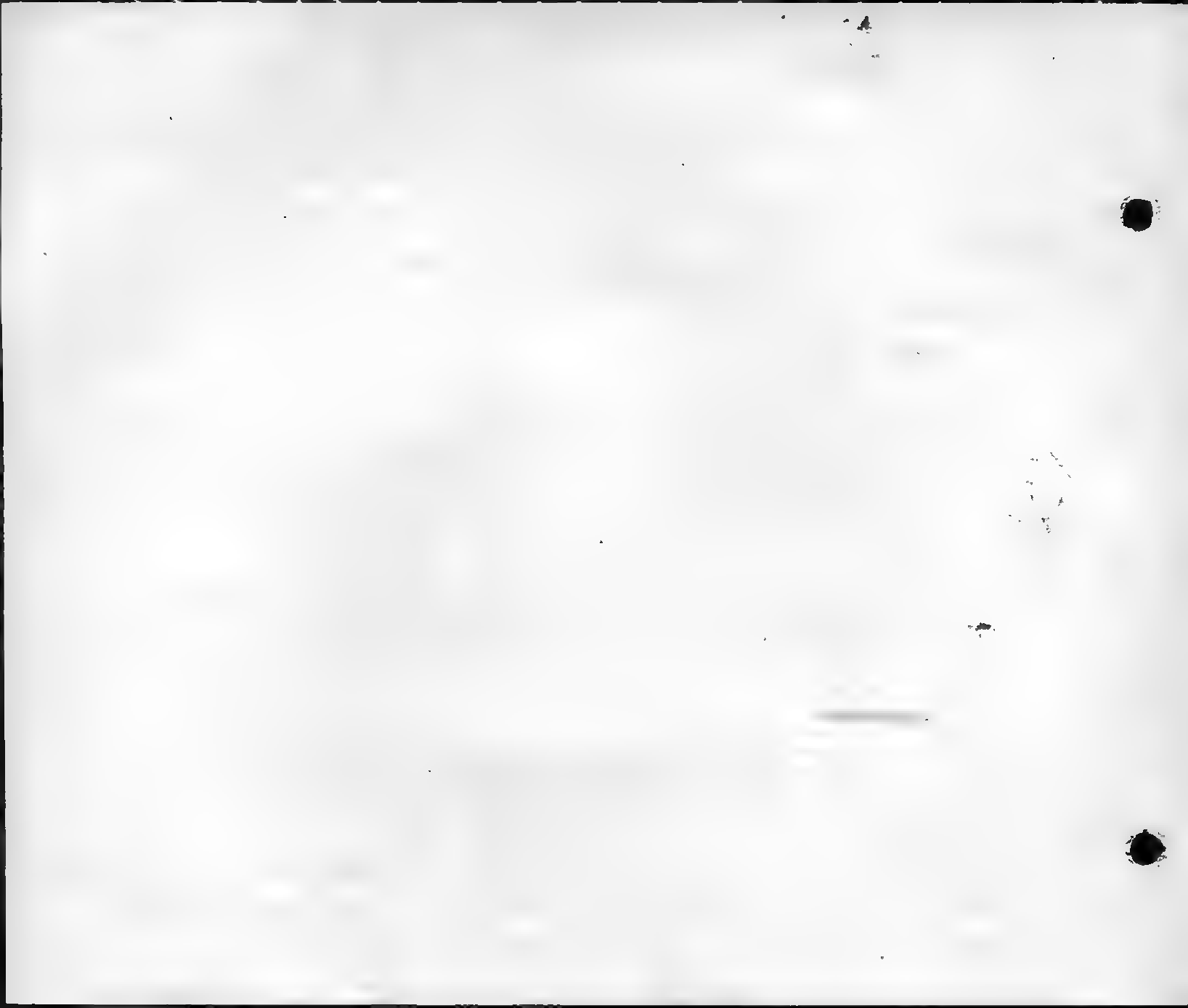
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
11564
CERTIFICATE OF DEATH

11487

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>1 mo 4 da</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Altus Vista Nursing Home</u>		e. STREET ADDRESS <u>5706 Warwick Pl.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last <u>Lillian B. Arthur</u>		4. DATE OF DEATH Month Day Year <u>Oct. 15 1960</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 27, 1886</u>
9. AGE (In years lost birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Simon Bauer</u>		14. MOTHER'S MAIDEN NAME <u>Ida Handberry Bauer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Mr. Wm. C. Arthur</u>		Address <u>5706 Warwick Pl. Chevy Chase, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Infarction, Massive</u> 464x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Thrombosis, same as?</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diphtheria Mellitus & Arteriosclerosis, generalized</u> 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day Year Hour <u>9:00</u> 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		INTERVAL BETWEEN ONSET AND DEATH	
21. I certify that (I) (this hospital) attended the deceased from <u>July 1960</u> to <u>10/15</u> 19 <u>60</u> that (I) last saw the deceased alive on <u>10/13</u> 19 <u>60</u> , and that death occurred at <u>12:29</u> PM, from the causes and on the date stated above		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. SIGNATURE <u>H. Luther Hall</u>		22b. DATE SIGNED <u>10/15/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>H. Luther Hall</u>		22d. ADDRESS <u>5410 Conn. Ave. Wash 15, D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/16/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Friends Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Sandy Spring, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
25a. REC'D BY REGISTRAR <u>OCT 18 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



1 *11*

11546

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11488
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3808 Underwood Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HOWARD Middle SHREEVE Last AUSTIN		4. DATE OF DEATH Month Oct. Day 18, Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 13, 1878
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months 2 Days 5 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Patent Attorney		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME James Brown Austin		14. MOTHER'S MAIDEN NAME Shepherd H. Handy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Yes	
17. INFORMANT Daughter		Address Same as Item #2	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LEUKEMIA DUE TO Carcinomatosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma STOMACH, LIVER (c) ANTERIOR SCLEROSIS, GENERALIZED		INTERVAL BETWEEN ONSET AND DEATH. 3-4 years 1-year 1+ year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ANTERIOR SCLEROSIS, GENERALIZED		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from **18 OCT. 1960** to **19 OCT. 1960**, that I last saw the deceased alive on **18 OCT. 1960**, and that death occurred at **10:10 P.M.** from the causes and on the date stated above.

ADDRESS (Street, city or town, state) **4890 BATTERY LANE** DATE SIGNED **10/19/60**

ACTUAL SIGNATURE **Charles J. Savarese** M.D. **CHARLES J. SAVARESE, M.D.**

PHYSICIAN'S NAME (Type) **CHARLES J. SAVARESE, M.D.**

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/21/60	22c. NAME OF CEMETERY OR CREMATORY Greenwood	22d. LOCATION (City, town, or county) (State) Washington, D. C.
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR DATE OCT 21 '60		24b. REGISTRAR'S SIGNATURE Carthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

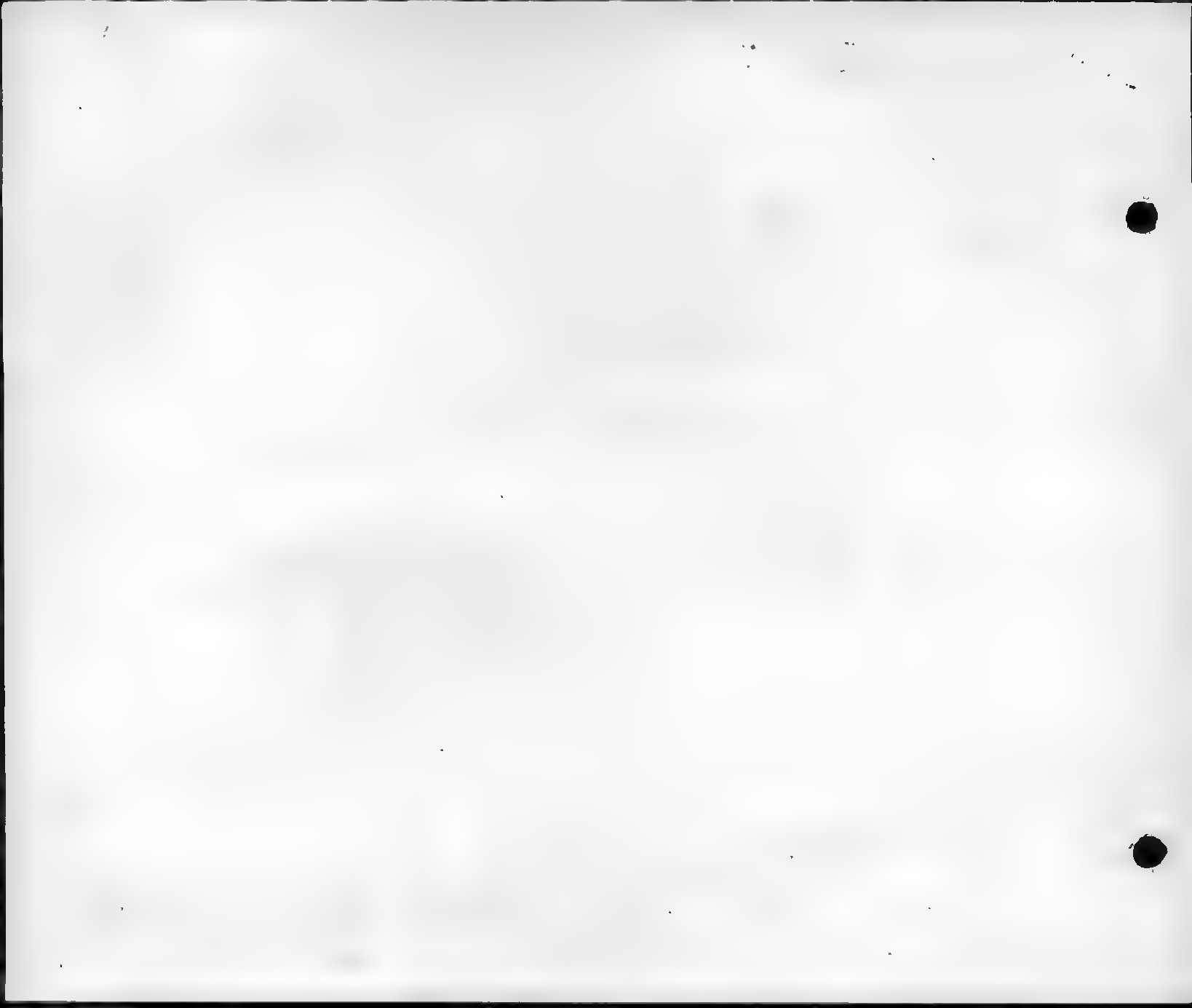


TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
11565
11489
CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7514 Marbury Road		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 7514 Marbury Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF Charles First Titus Middle Aylward Last		4. DATE OF DEATH October Month 9 Day 19 Year 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/26/1879
9. AGE (In years last birthday) 80 yrs		10. IF UNDER 1 YEAR 11 Months 13 Days	
11. IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Engineering	
11. BIRTHPLACE (State or foreign country) Maine		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Frank Aylward		14. MOTHER'S MAIDEN NAME Jenny Titus	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 024-10-0628	
17. INFORMANT Olive Aylward-wife-same 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: 42 C. IMMEDIATE CAUSE (a) ACUTE PULMONARY EDEMA DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 8 HRS. 4 YRS.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from MARCH, 1959 to OCT. 1960 that (I) (we) last saw the deceased alive on OCT. 8, 1960 and that death occurred at 11 AM , from the causes and on the date stated above.			
22a. SIGNATURE Leo M. Curtis		22b. DATE SIGNED OCT. 9, 1960	
22c. PHYSICIAN'S NAME (Type) Leo M. Curtis		22d. ADDRESS 8218 WISCONSIN AVE., BETHESDA, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit		23b. DATE THEREOF 10/12/60	
23c. NAME OF CEMETERY OR CREMATORY Puritan Lawn Cemetery		23d. LOCATION (City, town, or county) (State) Peabody, Massachusetts	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25a. REC'D BY REGISTRAR OCT 13 '60	
ADDRESS Bethesda, Maryland		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	



11503

CERTIFICATE OF DEATH

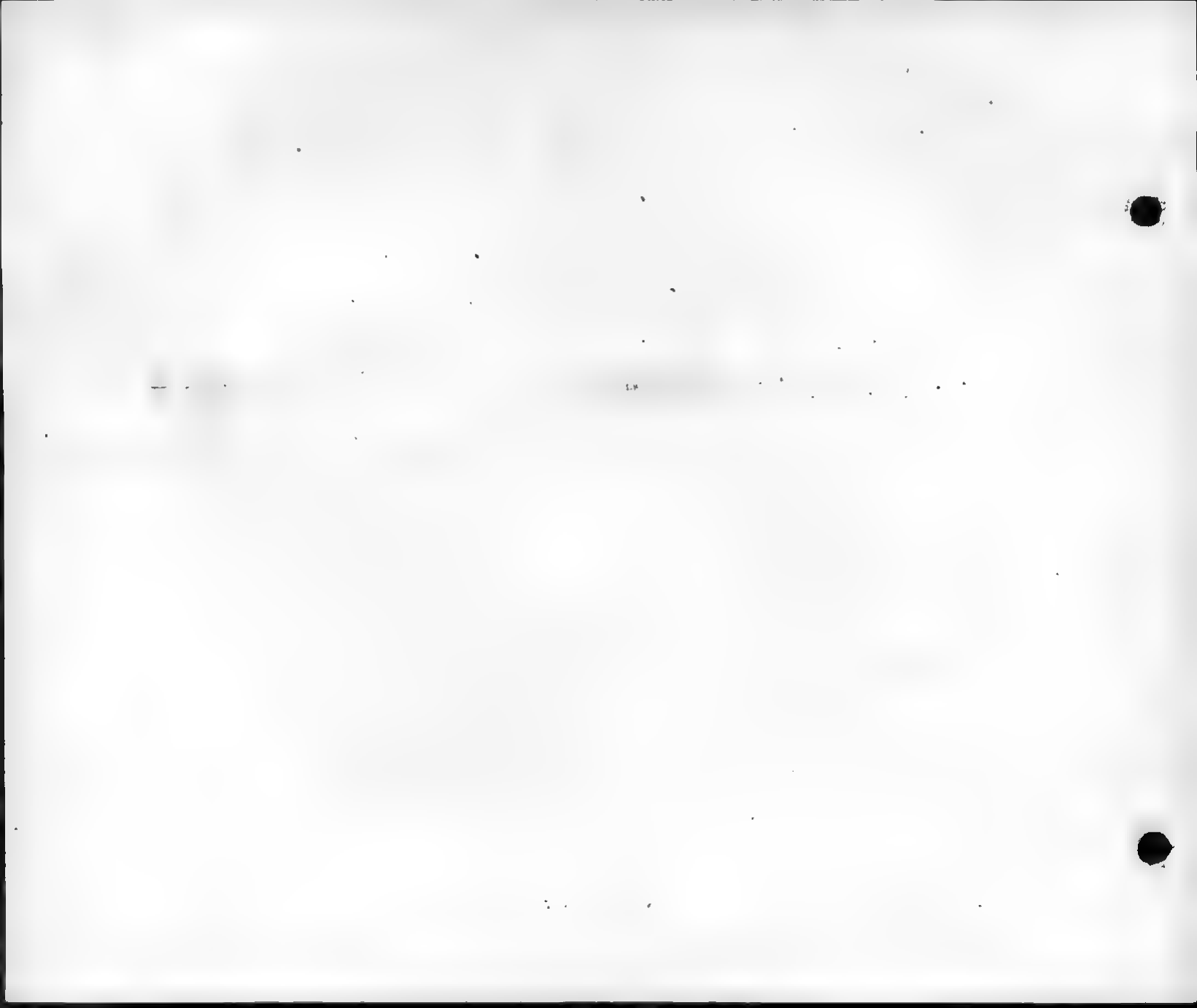
11490

Reg. Dist. No.

1 PLACE OF DEATH COUNTY MONTGOMERY MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a STATE DC b COUNTY 47X	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON - D.C.	
c. LENGTH OF STAY IN 1b 3 WEEKS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ATLANTA WOODLAND		d. STREET ADDRESS 3825 HARRISON ST	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last Bessie BATURIN		4. DATE OF DEATH Month Day Year 10 27 1960	
5 SEX F	6. COLOR OR RACE W	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 8, 1882
9. AGE (In years last birthday) 77 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME BAER, ARMERAN		14 MOTHER'S MAIDEN NAME HELEN	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) —		16 SOCIAL SECURITY N —	
INFORMANT Ac EDGAR BATURIN - 3825 HARRISON ST. N.W.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction, acute 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease. DUE TO (c) —			INTERVAL BETWEEN ONSET AND DEATH Days. Years.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 11, 1960 to Oct. 27, 1960 , that I last saw the deceased alive on 10-27-1960 , and that death occurred at 11:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Gene U. Cohen M.D.		ADDRESS (Street, city or town, state) 931 Pershing Drive, Silver Spring, Oct 28, 1960.	
DATE SIGNED Oct 28, 1960.			
PHYSICIAN'S NAME (Type) GENE U. COHEN			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 10-30-60	22c. NAME OF CEMETERY OR CREMATORY ADAS ISRAEL CEMETERY	22d. LOCATION (City, town, or county) (State) WASHINGTON - DC
23. FUNERAL DIRECTOR'S SIGNATURE BERNARD DANZANSKY & SONS - 3501-14th ST. N.W.		24a. REC'D BY REGISTRAR DATE NOV 1 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



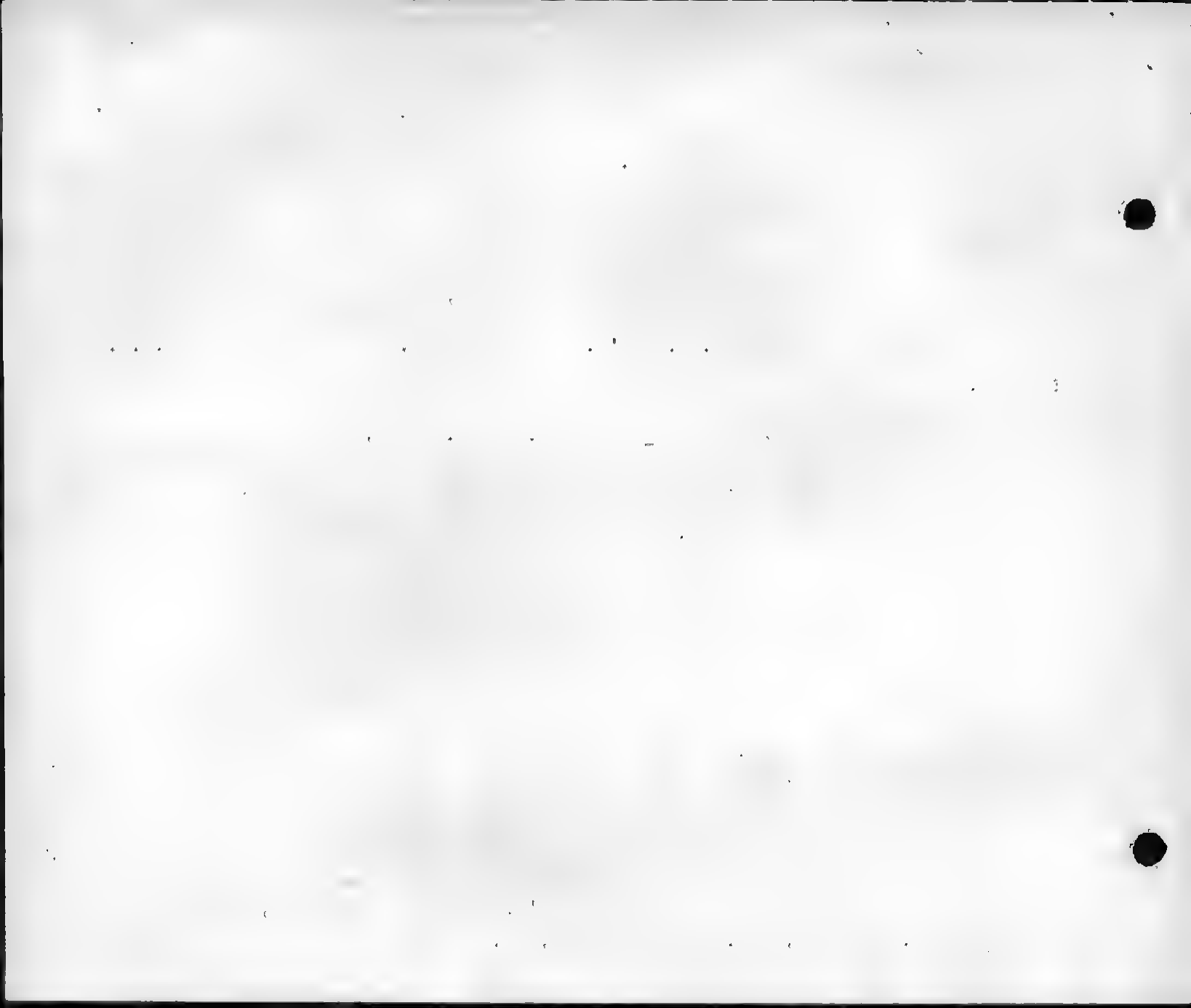
UNITED STATES DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11504

11491

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			c. LENGTH OF STAY IN 1b 8 yrs.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8304 16th Street				d. STREET ADDRESS 8304 16th Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Cornelius Middle Last Beard				4. DATE OF DEATH Month Oct Day 7 Year 1960			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 23, 1886		9. AGE (In years last birthday) 74 yrs	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Engineer (retired)		10b. KIND OF BUSINESS OR INDUSTRY U. S. Gov't.		11. BIRTHPLACE (State or foreign country) Mass.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Cornelius Beard				14. MOTHER'S MAIDEN NAME Anais Bonabel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WW #1 & #2 229-14-8663		17. INFORMANT Address Mrs. Amy L. Beard, 8304 16th Street Silver Spring, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) coronary atherosclerosis DUE TO (c)</p> </div> <div style="width: 35%;"> <p>INTERVAL BETWEEN ONSET AND DEATH 6 hrs. 10 yrs.</p> </div> </div> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) this hospital attended the deceased from Jan 1951 to Oct 1960 that (I) we last saw the deceased alive on Oct 7, 1960 , and that death occurred at 9 AM , from the causes and on the date stated above.							
22a. SIGNATURE [Signature]				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) H. F. Kreuzburg				22d. ADDRESS 2852 16th St NW Wash DC			
23a. BURIAL, CREMAT. OR REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/11/60		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY		23d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
24. FUNERAL DIRECTOR'S SIGNATURE WERNER E. PUMPHREY, INC. SILVER SPRING, MD. [Signature]				25a. REC'D BY REGISTRAR DATE OCT 13 '60		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11566

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11493

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>34 Silver Spring.</u>			
c. LENGTH OF STAY IN 1b <u>Since 9/28/60</u>				d. STREET ADDRESS <u>112718 Gould Rd.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Catherine</u> Last <u>Bowers</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>21</u> Year <u>1960</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 24 1906</u>	
9. AGE (in years last birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. Store</u>			
11. BIRTHPLACE (State or foreign country) <u>Mont. Co. Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Charles W. Brown</u>				14. MOTHER'S MAIDEN NAME <u>Alice May Disney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>579-07-9104</u>			
17. INFORMANT <u>Francis E. Davis</u>				Address <u>1500</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>581.0</u> DUE TO <u>Negative failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Overhauled of the brain</u> DUE TO <u>10 yrs</u> (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. <u> </u> Day. <u> </u> Year <u>19</u> Hour a. m. <u> </u> p. m. <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> of work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 28, 1960</u> to <u>Oct 21, 1960</u> that (I) (we) last saw the deceased alive on <u>Oct 21, 1960</u> , and that death occurred <u>6:30</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Horace W. Bernton</u> M.D.				22b. DATE SIGNED <u>10/22/60</u>			
22c. PHYSICIAN'S NAME (Type) <u>HORACE W. BERNTON</u>				22d. ADDRESS <u>10511 Summit Ave., Kensington, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>10/24/60</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>				23d. LOCATION (City, town or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wagner E. Pimphrey, Inc.</u>				25a. REC'D BY REGISTRAR <u>ACT 25 '60</u>			
ADDRESS <u>SILVER SPRING, MD.</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any fee is necessary, it should be paid to the funeral director. Page 1 of 3 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 2 may be retained for your files. Page 3 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 3 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

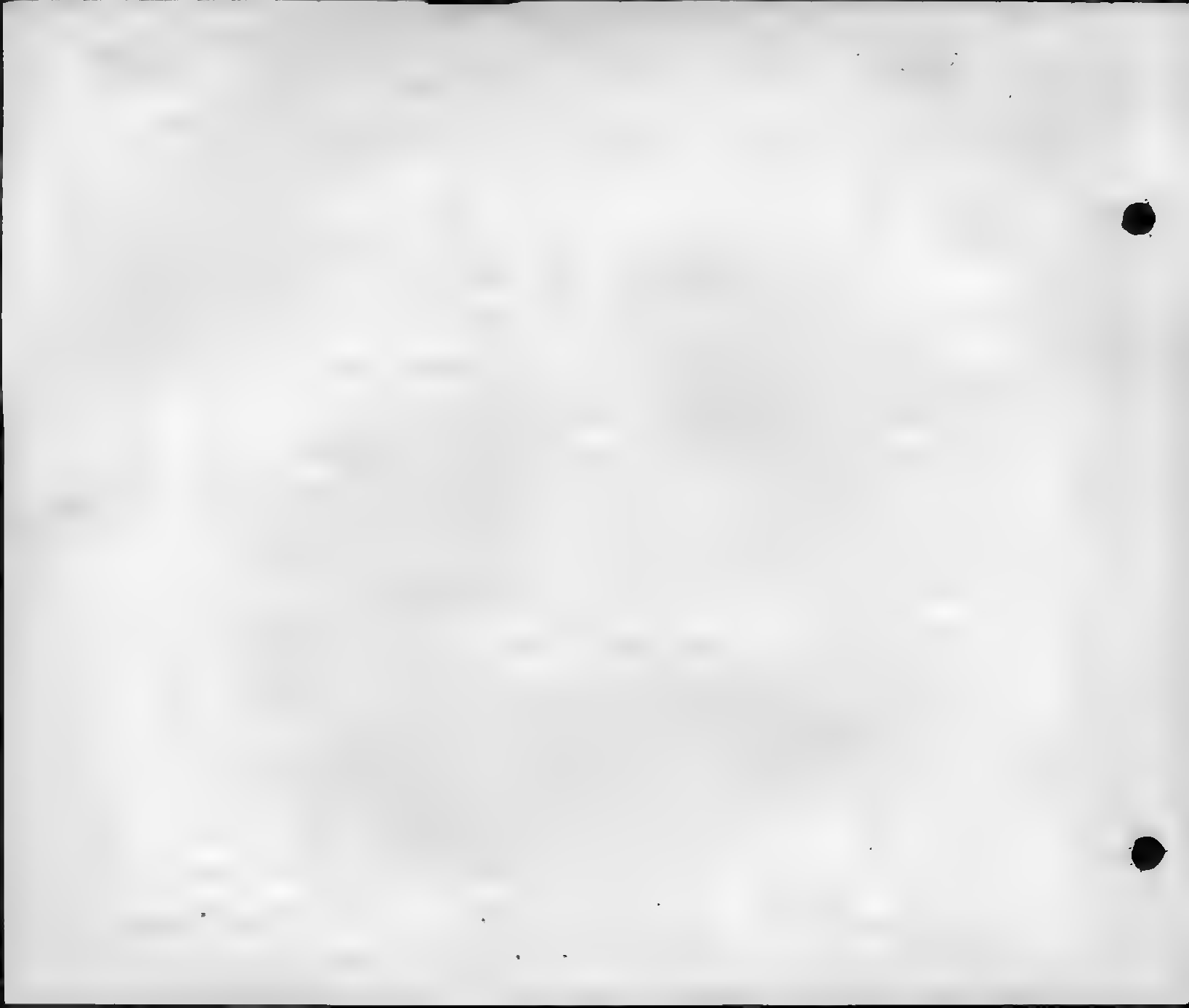
11557

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11494

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived, if institutions; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville (rural)</u>			
c. LENGTH OF STAY IN 1b <u>40 yrs</u>				d. STREET ADDRESS <u>1 Emory Lane</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Emory Lane</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Charles Henry Boyer</u>				4. DATE OF DEATH <u>Oct 6 1960</u>			
5. SEX <u>male</u>				6. COLOR OR RACE <u>col</u>			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>4-15-1891</u>			
9. AGE (in years last birthday) <u>69</u> yrs.				10. IF UNDER 1 YEAR: IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labner</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Del.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>			
13. FATHER'S NAME <u>Mamuel Boyer</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Bessie Boyer (wife)</u>				Address <u>John 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>sudden</u> (a), stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschant</u>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>10-6-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>10/11/60</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National,</u>				22d. LOCATION (City, town, or country) (State) <u>Arlington, Va.</u>			
23. FUNERAL DIRECTOR <u>Robert L. Snowden</u>				ADDRESS <u>Rockville, Md.</u>			
24a. REC'D BY REGISTRAR				24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>			
DATE <u>OCT 13 '60</u>							

MEDICAL CERTIFICATION



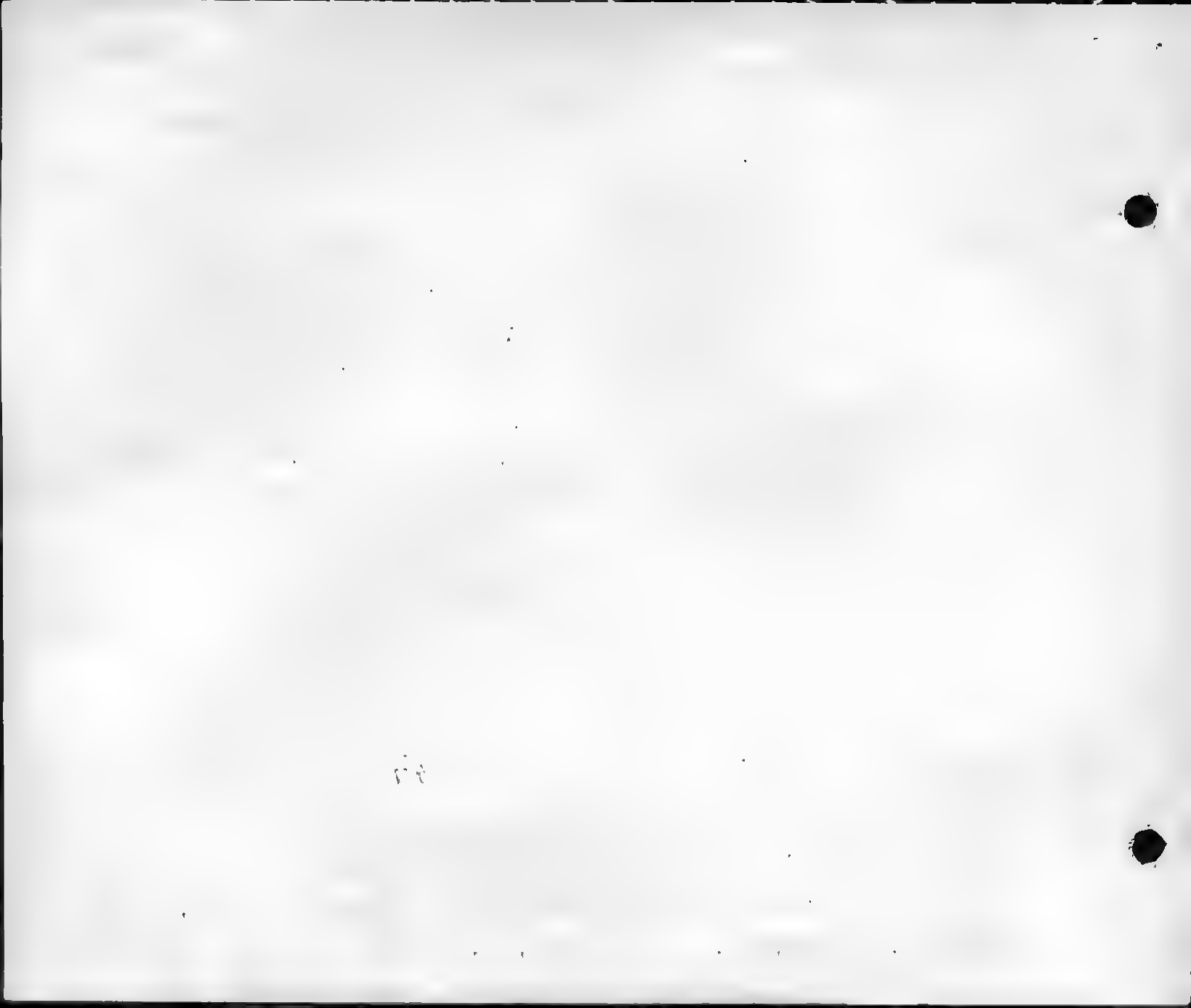
may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11567

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11495

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1st, West Spring.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>12703-Lindell St.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles W. Bradley</u>				4. DATE OF DEATH Month Day Year <u>Oct. 27 1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/23/42</u>	
9. AGE (In years last birthday) <u>17</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, given if retired) <u>Student</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Wheaton High School</u>		11. BIRTHPLACE (State or foreign country) <u>Washington D.C. U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Ferry E. Bradley</u>				14. MOTHER'S MAIDEN NAME <u>Estelle Lillian Thayer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Ferry E. Bradley</u> Address <u>same as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Lymphosarcoma</u> DUE TO <u>20c.1</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>7 months</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>March 11, 1959</u> to <u>Oct 27, 1960</u> , that (I) (we) last saw the deceased alive on <u>Oct 27, 1960</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above							
22a. SIGNATURE <u>Philip E. Jones</u> M.D.				22b. DATE SIGNED <u>Oct 27, 1960</u>			
22c. PHYSICIAN'S NAME (Type) <u>PHILIP E. JONES</u>				22d. ADDRESS <u>980 1st St. S.W. Wash. D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10/31/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Walter E. Pumphrey, Inc.</u> ADDRESS <u>SILVER SPRING, MD.</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 2 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Chas. S. Thayer</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11519

CERTIFICATE OF DEATH

11496

Item 6 Film 6215 10-26-60 et

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY Mont.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
c. LENGTH OF STAY IN 1b 14 days		d. STREET ADDRESS 15730 Peach Orchard Blvd.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington San. and Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last AGNUS Loretta Brady		4. DATE OF DEATH Month Day Year Oct 14 1960	
5. SEX female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-18-97
9. AGE (In years last birthday) 63 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hswf.	11. BIRTHPLACE (State or foreign country) N.Y.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME James Blauvelt		14. MOTHER'S MAIDEN NAME Ellen Mc Donnell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 153 IMMEDIATE CAUSE (a) terminal hypoxia, myocardial infarction DUE TO ex of target vessel @ intonation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO hypertension (arterial) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arteriosclerosis @ atherosclerosis			
INTERVAL BETWEEN ONSET AND DEATH 24 hrs			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 29, 1960 to Oct. 14, 1960 , that (I) (we) last saw the deceased alive on Oct. 13, 1960 , and that death occurred at 7:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Paul Lane		22b. DATE SIGNED 10-14-60	
22c. PHYSICIAN'S NAME (Type) PAUL LANE MD		22d. ADDRESS 6127-16th St. N.W. Wash. D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10/17/60	23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY	23d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND
24. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PIMPHREY, INC.		25a. REC'D BY REGISTRAR DATE OCT 19 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Thoma			



1
FOR STATE
HEALTH DEPT.

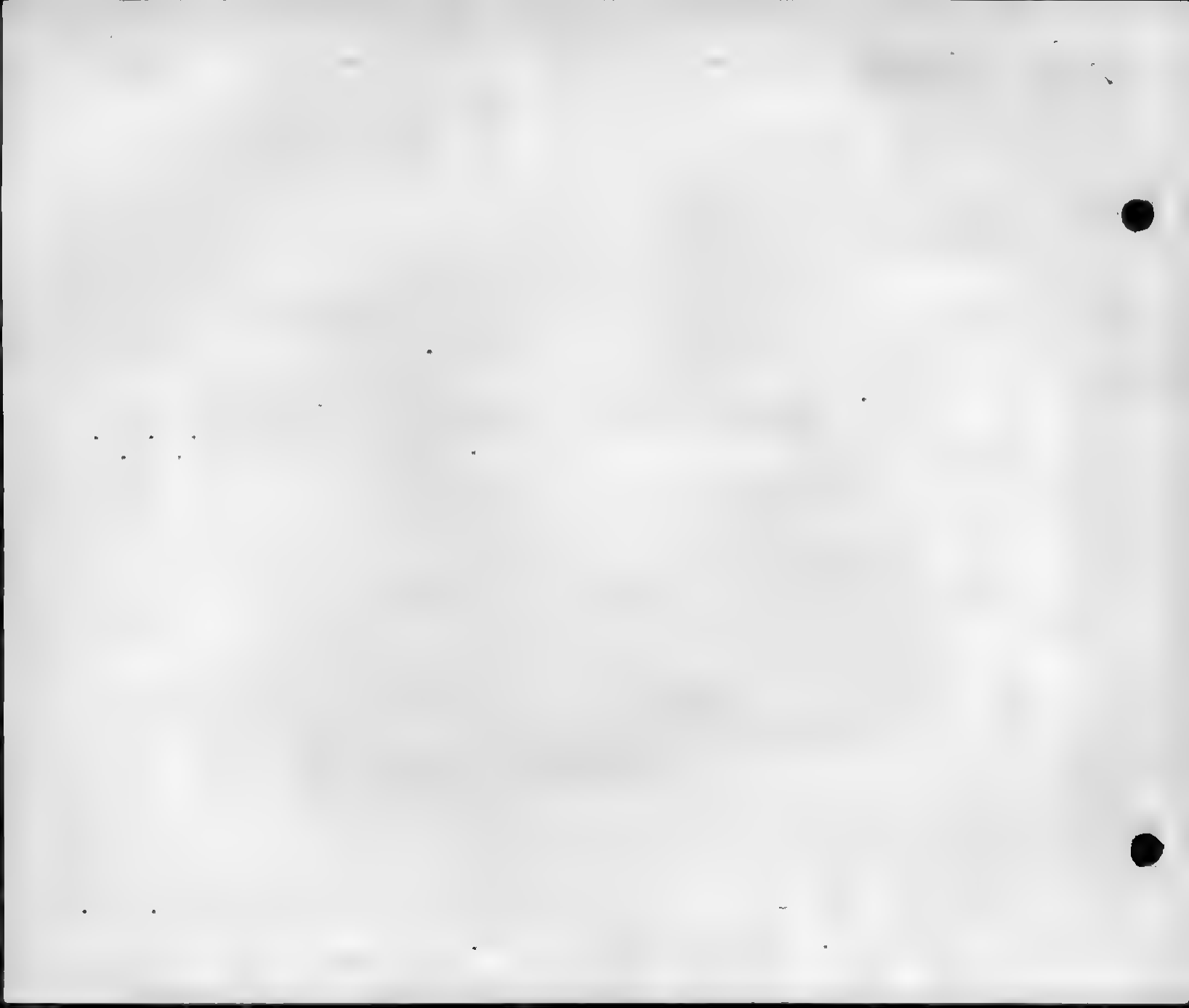
THIS CERTIFICATE SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER'S OFFICE ALONG WITH FORM PM-3. PAGE 5 MAY BE RETAINED FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. FILE PAGES 1 AND 2 WITH THE STATE BOARD OF HEALTH, OR ITS DESIGNATED AGENT, PRIOR TO BURIAL, CREMATION, OR REMOVAL, AND IN ANY EVENT WITHIN 72 HOURS AFTER DEATH.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
11568 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11497									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>					2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4707 Chevy Chase Dr</u>					d. STREET ADDRESS <u>14707 Chevy Chase Dr</u>				
3. NAME OF DECEASED (Type or print) <u>Ward W. Brewer</u>					4. DATE OF DEATH <u>Oct 18 1960</u>				
5. SEX <u>male</u>					6. COLOR OR RACE <u>white</u>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>12-24-08</u>				
9. AGE (In years, last birthday, Months, Days, Hours, Min.) <u>51 yrs.</u>					10. IF UNDER 1 YEAR <u>51</u> yrs.				
11. BIRTHPLACE (State or foreign country) <u>Conn.</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>Harry J. Brewer</u>					14. MOTHER'S MAIDEN NAME <u>Hattie ? Unknown</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>No</u>					16. SOCIAL SECURITY NO. <u>Joel P. Brewer</u>				
17. INFORMANT <u>Son</u>					18. ADDRESS <u>4707 Ch. Ch. Dr. Bethesda, Md.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u>									
331X DUE TO									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO									
DUE TO									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
<u>History of previous C.V.A.</u>									
20a. EXTERNAL CAUSE (Was PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>10-18-60</u>									
Address (Street, city, town, or county)									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>									
22b. DATE THEREOF <u>10-20-60</u>									
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>									
22d. LOCATION (City, town, or country) (State) <u>Prince George Co., Md.</u>									
23. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY</u> ADDRESS <u>Bethesda, Md.</u>									
24a. REC'D BY REGISTRAR <u>Oct 24 '60</u>									
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>									

INTERVAL BETWEEN ONSET AND DEATH
Fatal death on floor at home



11569

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11498

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 36 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington				d. STREET ADDRESS 906 P Street, N.W.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Alice Middle (None) Last Brown		4. DATE OF DEATH		Month October Day 13 Year 1960	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH October 17, 1907	9. AGE (In years last birthday) 52 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Cleaning		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Grannison				14. MOTHER'S MAIDEN NAME Susan Flam			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Collapse INTERVAL BETWEEN ONSET AND DEATH 53 Hrs. DUE TO (b) Bacteremic Shock 53 Hrs. DUE TO (c) Carcinoma of Cervix 20 Months Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Urinary and Intestinal Fistula, Renal Shutdown, Post-operative							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from September 7, 1960 , that (I) (we) last saw the deceased alive on October 13, 1960 , and that death occurred at 4:25 AM from the causes and on the date stated above							
22a. SIGNATURE David T. Crawford				22b. DATE SIGNED 10-13-60			
22c. PHYSICIAN'S NAME (Type) DAVID T. CRAWFORD, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) 10-17-60		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY West Harmony Memorial		23d. LOCATION (City, town, or county) (State) 7.14	
24. FUNERAL DIRECTOR'S SIGNATURE Frederick J. Howell Home Inc. 389 R. 2 Ave NW				25a. REC'D BY REGISTRAR DATE OCT 17 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The permit remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

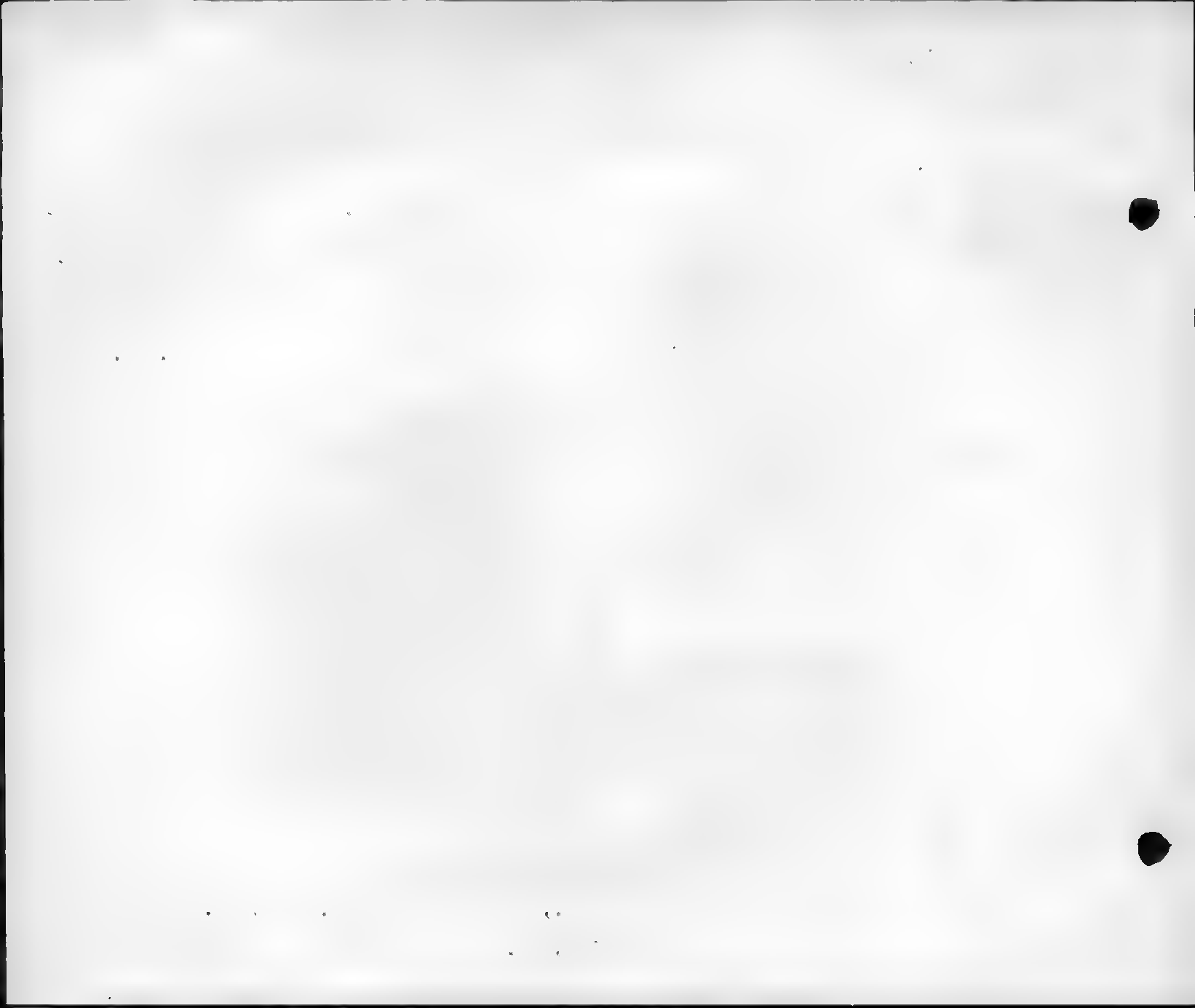
1

11570

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11499

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg (Rural)</u>				c. LENGTH OF STAY IN 1b <u>1</u> <u>Silver Spring., (Rural)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ammons Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ULYESSES</u> Middle <u>BROWN</u> Last <u>BROWN</u>				4. DATE OF DEATH Month <u>October</u> Day <u>2</u> Year <u>19 60</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1866</u>		9. AGE (In years last birthday) <u>94</u> yrs	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Brown</u>				14. MOTHER'S MAIDEN NAME <u>Sarah ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Nursing Home Records</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>422.5</u> DUE TO <u>Heart Failure</u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Chronic Myocarditis</u> (b) DUE TO <u> </u> (c) DUE TO <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>about 3 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS A TUPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1959, 19</u> to <u>Oct 2, 1960</u> , that (I) (we) last saw the deceased alive on <u>Oct 1, 1960</u> , and that death occurred at <u>7 P.</u> M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Luciano I. Led</u>				M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Luciano I. Led</u>				22d. ADDRESS <u>Gaithersburg, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/5/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove.,</u>		23d. LOCATION (City, town, or county) (State) <u>Mt. Zion, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Anderson</u>				ADDRESS <u>Rockville, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 7 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur L. Howard</u>			



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11571

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11500

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clarksburg, Md.</u>	
c. LENGTH OF STAY IN 1b <u>3 hrs.</u>		d. STREET ADDRESS <u>Route 55—Hammerhill</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Ira</u> Last <u>Burnett</u>		4. DATE OF DEATH Month <u>October</u> Day <u>11</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 29 1944</u>
9. AGE (In years last birthday) <u>16</u> yrs.		IF UNDER 1 YEAR Months <u>16</u> Days <u>16</u> Hours <u>16</u> Min. <u>16</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas E. Burnett</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Miller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Mr. Thomas Burnett (father)</u>	
17. INFORMANT <u>Mr. Thomas Burnett (father)</u>		Address <u>155</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Central gunshot & laceration</u> DUE TO (b) <u>bullet wound in skull</u> DUE TO (c) <u>3 1/2 hrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>170x</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OF CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Self-inflicted bullet wound</u>	
20c. TIME OF INJURY Month, Day, Year <u>10-10</u> p.m. <u>10-10</u> 19 <u>60</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>Clarksburg monty md</u> (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Brosch</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>10-12-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		22d. LOCATION (City, town, or county) <u>Bladensburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner</u>		24a. REC'D BY REGISTRAR <u>10-11-60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kuss</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 11500. Pages 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be required by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

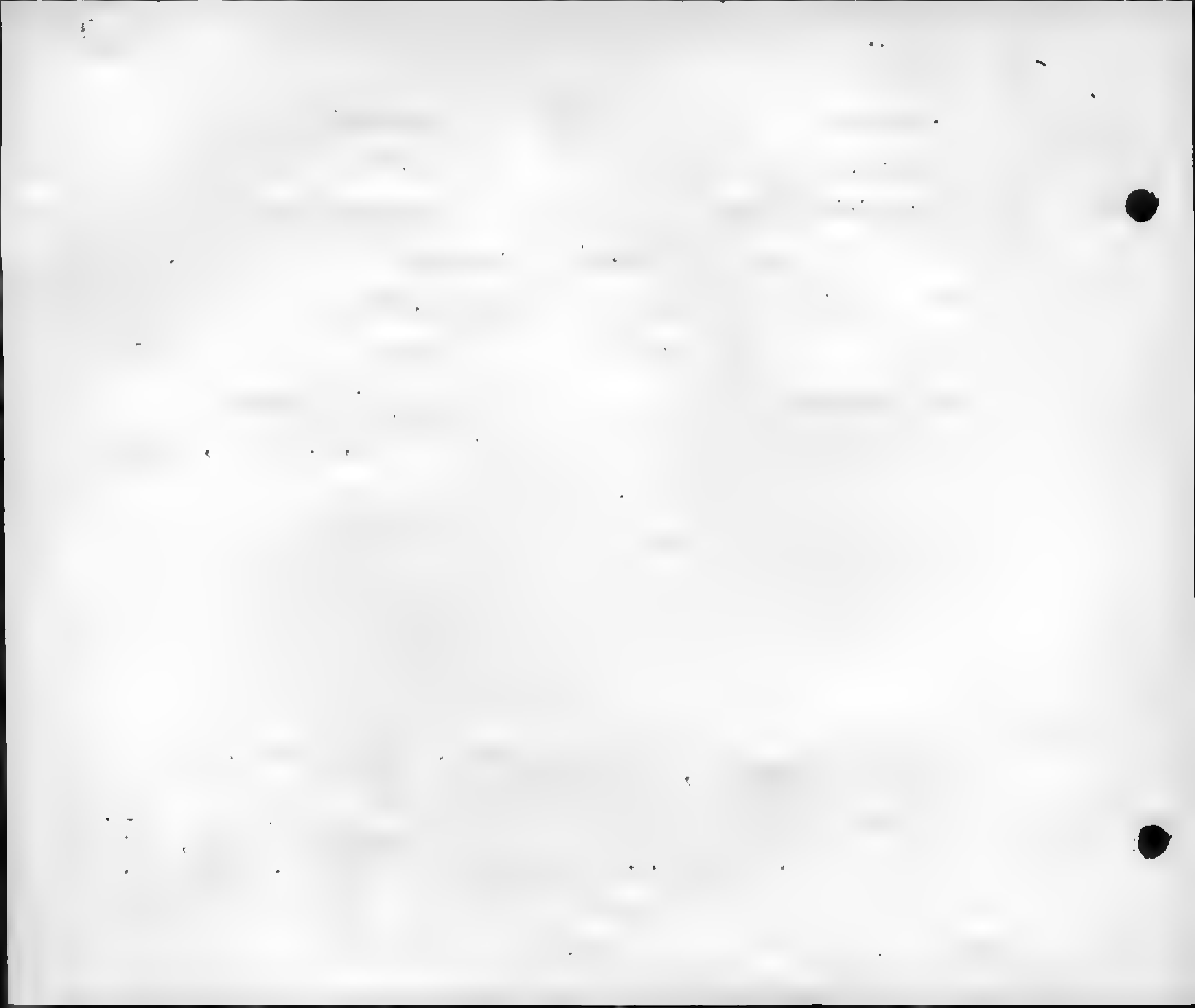
VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11572

11501

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Johnstown	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center		d. STREET ADDRESS 606 Warner Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Nancy Middle (none) Last Burrafato		4. DATE OF DEATH Month October Day 6 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 19, 1943
9. AGE (In years last birthday) 16 yrs.		10. IF UNDER 1 YEAR: Months 16 Days 16 Hours 16 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? Italy	
13. FATHER'S NAME George Burrafato		14. MOTHER'S MAIDEN NAME Mary (Maria) Sunzere	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. The Medical Record	
17. INFORMANT The Clinical Center, Bethesda 14, Maryland		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac arrest 434.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Primary Pulmonary Hypertension DUE TO (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 45 Minutes 2 Years		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from October 5, 1960 , to October 6, 1960 , that (I) (we) last saw the deceased alive on October 6, 1960 , and that death occurred at 12 Noon from the causes and on the date stated above.			
22a. SIGNATURE Rose V. Levine M.D.		22b. DATE SIGNED 10-7-60	
22c. PHYSICIAN'S NAME (Type) Robert J. Levine, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 10-7-60		23b. DATE THEREOF 10-7-60	
23c. NAME OF CEMETERY OR CREMATORY St. Anthony's Cemetery		23d. LOCATION (City, town, or county) (State) Johnstown, Penna.	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.	
25a. REC'D BY REGISTRAR OCT 13 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11502

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If instit. on Res. dence before adm. on) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>4524 N. Chelsea La.</u>	
3. NAME OF DECEASED (Type or print) <u>Susan</u>		4. DATE OF DEATH Month <u>10</u> Day <u>11</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/27/58</u>
9. AGE (In years last birthday) <u>22</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clifford C. Butler</u>		14. MOTHER'S MAIDEN NAME <u>Jane Davidson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Jane Butler</u>		Address <u>mother</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Herniation of Brain Stem</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Intracerebral edema</u> (c) <u>Epidural Hematoma, left</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Not known</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.) <u>Not known</u>	
20c. TIME OF INJURY Month <u>?</u> Day <u>19</u> Hour <u>?</u> a. m. <u>?</u> p. m. <u>?</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Bethesda</u>	20f. (City or town) <u>Montg.</u> (County) <u>Md.</u> (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/14/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) <u>Rockville Md</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>Arthur S. Thomas</u>		24b. REGISTRAR'S SIGNATURE	
DATE <u>OCT 13 '60</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

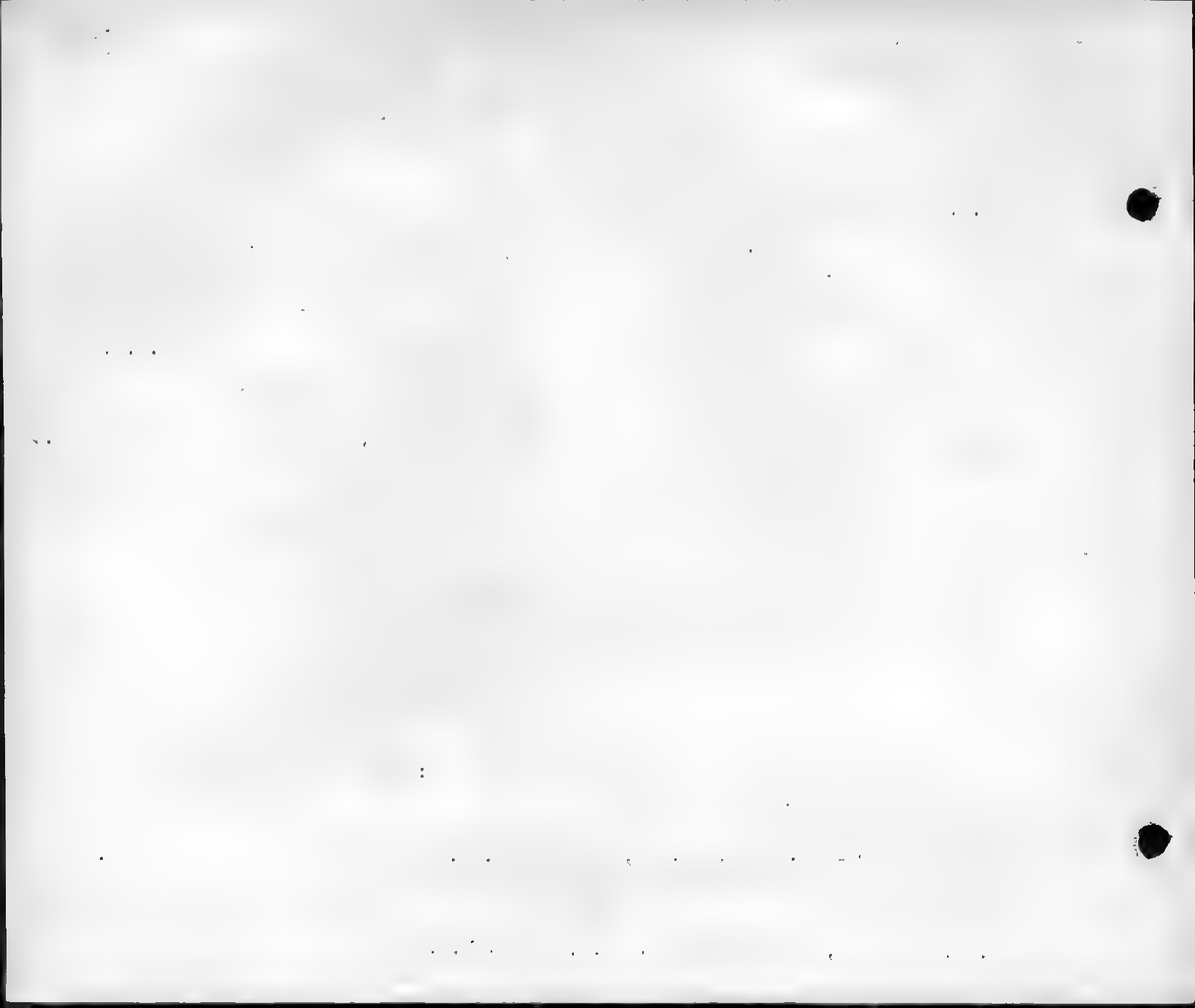
11574

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11503

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 42 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Pennsylvania b. COUNTY Jamestown c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jamestown d. STREET ADDRESS RD #1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mark Allen CAMPBELL				4. DATE OF DEATH Month Day Year OCTOBER 1 19 60			
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-23-59	9. AGE (In years lost birthday) yrs 1	10. UNDER 1 YEAR Months Days 1	11. UNDER 24 HRS Hours Min 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY Child		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Paul Herman CAMPBELL			14. MOTHER'S MAIDEN NAME Leticia Roseann PRESTO				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None		17. INFORMANT Paul H. CAMPBELL, 22 Barnacle Green, Wash, D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEMORRHAGE, GASTRIC, MESTINYL 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) LEUKEMIA, ACUTE LYMPHOGEN DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (a) (this hospital) attended the deceased from 7-20-1960 to 10-1-1960 , that (b) (we) last saw the deceased alive on 10-1-1960 and that death occurred on 10-1-1960 at 2:48AM from the causes and on the date stated above. 22a. SIGNATURE Robert V. Rack M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED 10-1-60 22c. PHYSICIAN'S NAME (Type) Robert V. RACK, LT, MC, USN 22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment		23b. DATE THEREOF 10/1/60		23c. NAME OF CEMETERY OR CREMATORY Catholic		23d. LOCATION (City, town, or county) (State) Greenville, Pennsylvania	
24. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS, 1400 Chapin St., N.W., Wash. D.C. ADDRESS				25a. REC'D BY REGISTRAR DATE OCT 3 '60		25b. REGISTRAR'S SIGNATURE Robert S. Hume	

MEDICAL CERTIFICATION



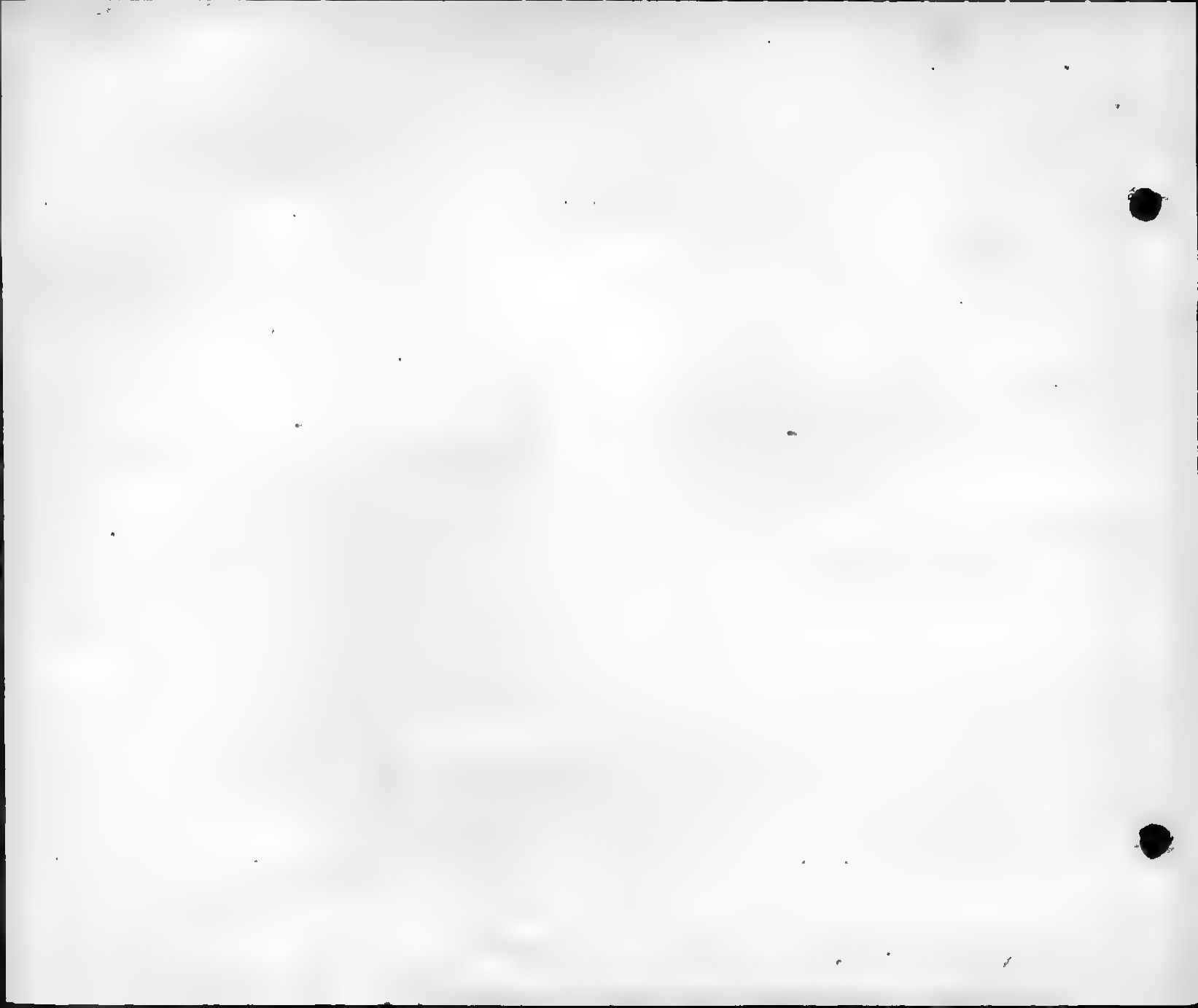
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11575

11504

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SULURBAN Hospital				e. STREET ADDRESS 10 ROSEMOUNT DR.			
3. NAME OF DECEASED (Type or print) First Middle Last OPAL M CAMPBELL				4. DATE OF DEATH Month Day Year OCT 18 19 60			
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/31/22		9. AGE (In years last birthday) 37 yrs	10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Minn.		12 CITIZEN OF WHAT COUNTRY? U.S.A	
13 FATHER'S NAME Rudolph Kruger				14. MOTHER'S MAIDEN NAME Clara Scherer			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16 SOCIAL SECURITY NO. None		17 INFORMANT Address Cyril Campbell-Husband-same 2d			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) OVERWHELMING TOXEMIA DUE TO PRIMARY PERITONITIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PRIMARY PERITONITIS DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 4 DAYS	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a)						19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a m p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 10-17-60 to 10-18-60 , that (I) (we) last saw the deceased alive on 10-18-60 , and that death occurred at 3:30 M, from the causes and on the date stated above.							
22a. SIGNATURE J. P. McCarrick MD				22b. DATE SIGNED 10-18-60			
22c. PHYSICIAN'S NAME (Type) J. P. McCarrick MD				22d. ADDRESS 809 Viers Mill Rd. Rockville, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/21/60		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City, town, or county) (State) Rockville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Robert A. Pumphrey Bethesda, Maryland				25a. REC'D BY REGISTRAR DATE OCT 21 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Thoma	



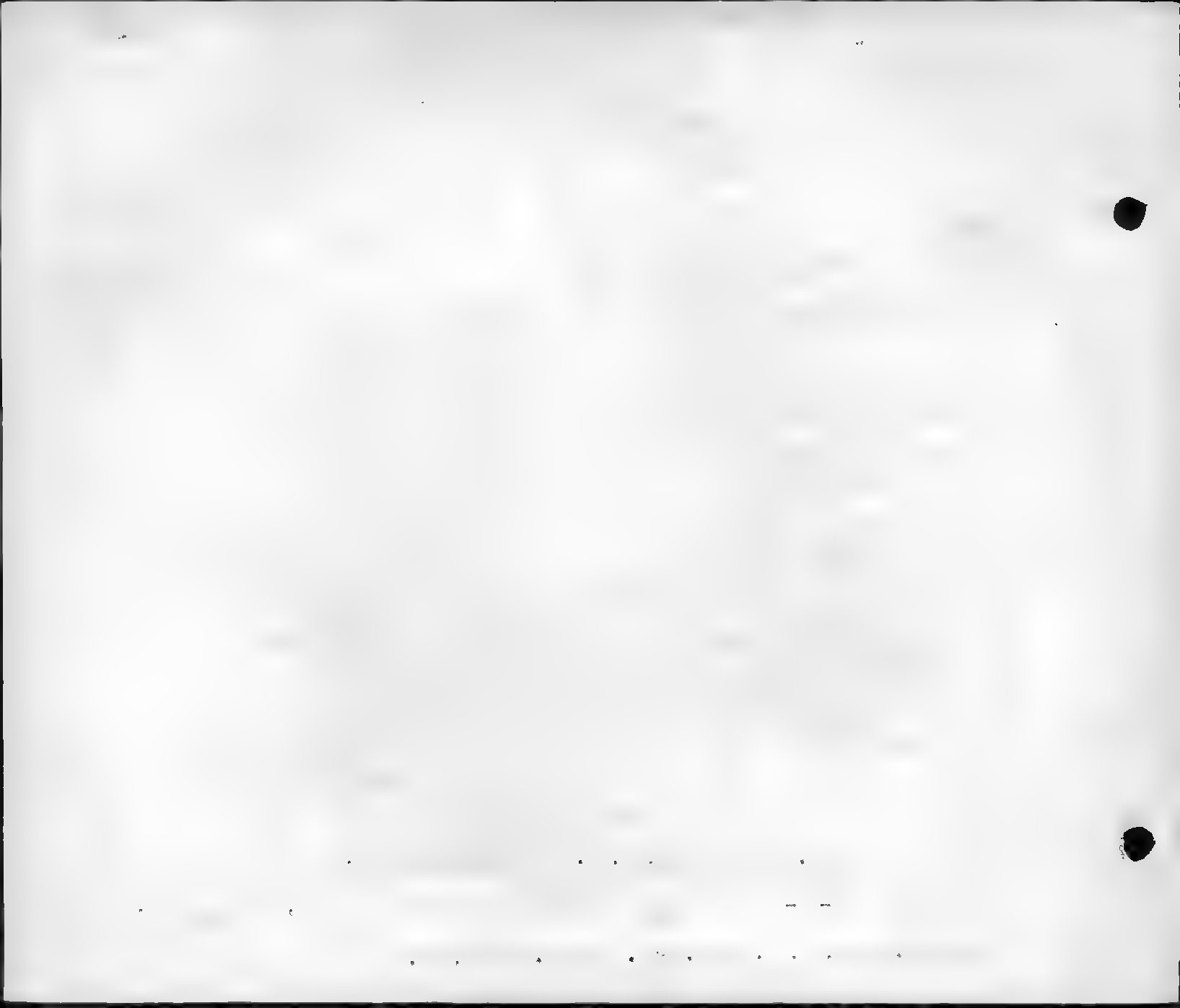
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>S.E. Washington D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>(Infant)</u> Middle <u>Carico</u> Last <u>Carico</u>		4. DATE OF DEATH Month <u>October</u> Day <u>28</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-20-60</u>
9. AGE (In years last birthday) yrs. <u>—</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>USA - Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Washington Carico</u>		14. MOTHER'S MAIDEN NAME <u>Jeanne Katherine Clark</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO <u>—</u>	
17. INFORMATION <u>Hospital Records</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Prematurity</u>			
DUE TO <u>762.5</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Asphyxia (pulmonary hyaline membrane)</u>			
DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/20</u> , 19 <u>60</u> , to <u>10/21</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>10/21</u> , 19 <u>60</u> , and that death occurred at <u>—</u> M, from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>College Park, Md</u> DATE SIGNED <u>10/21/60</u>			
ACTUAL SIGNATURE <u>Thomas A. Christenson</u> M.D. <u>—</u>			
ENTICIAN'S NAME (Type) <u>Thomas A. Christenson, M. D.</u> <u>College Park, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>10-21-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium and Hospital, Takoma Park, Maryland</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Hare, M. D. Wash. San. & Hosp. Tk Pk, Md.</u>		24a. REC'D BY REGISTRAR <u>OCT 25 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Carlton L. Kinn</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



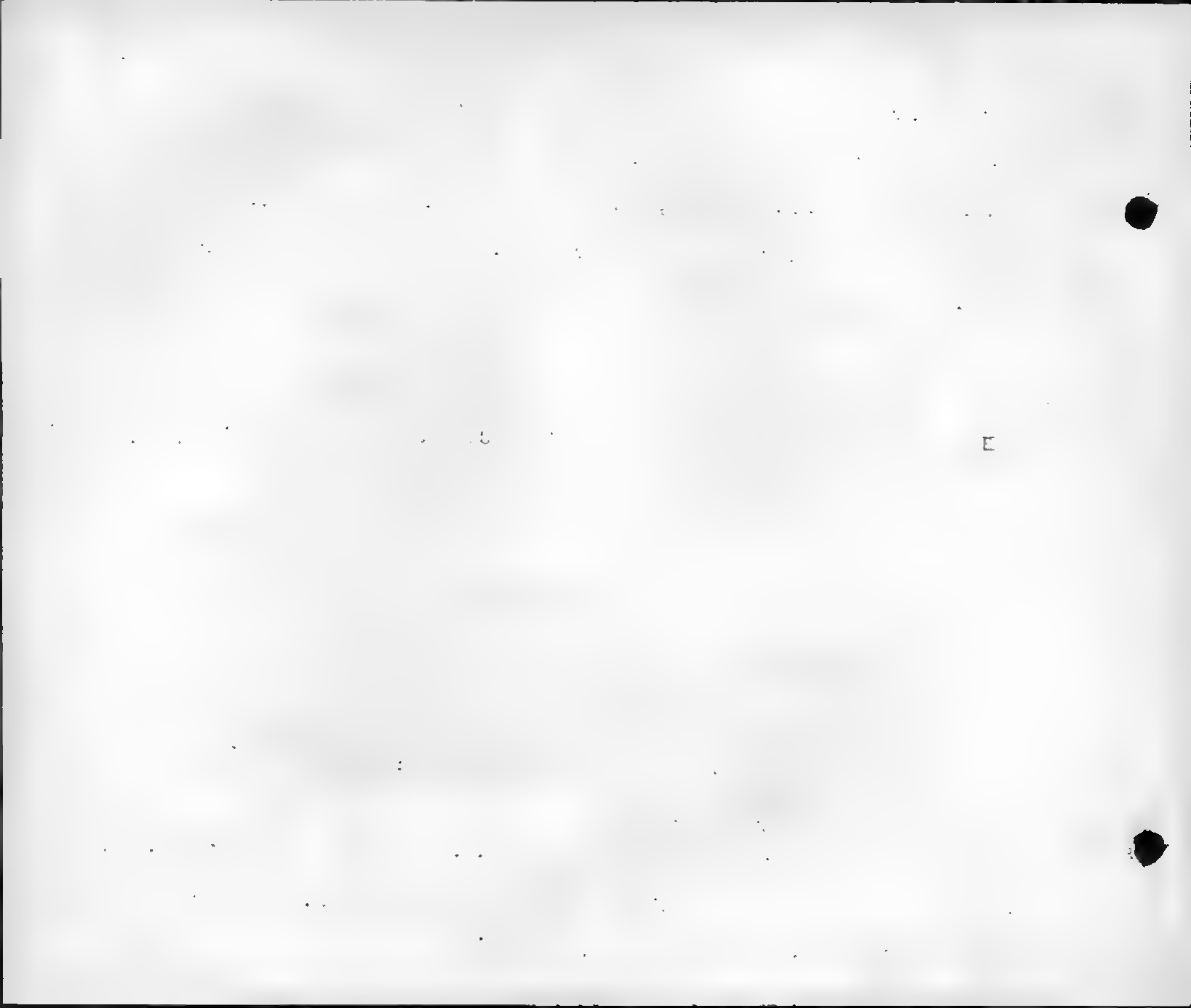
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11576

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11506

1. PLACE OF DEATH COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 49 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Virginia Middle Backstrom Last CASSEDY		4. DATE OF DEATH Month October Day 22 Year 1960	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-23-08
9. AGE (In years and birthday) 52 yrs.		10. F UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - -	
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Theodore Edward BACKSTROM		14. MOTHER'S MAIDEN NAME Helen RICHARDS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unk	
17. INFORMANT Hiram Cassedy (Husband)		Address 886 N. Kensington St. Arlington, Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: Adenocarcinoma of Rectum with Metastases 154x DUE TO (a) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month. Day. Year Hour o m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that xxx (this hospital) attended the deceased from 3 September 1960 to 22 October 1960 , that he (we) last saw the deceased alive on 22 Oct. 1960 , and that death occurred at 11:15 AM from the causes and on the date stated above.			
22a. SIGNATURE Rexford H. Hunt Jr.		22b. ADDRESS U.S. Naval Hospital, Bethesda, Md.	
22c. PHYSICIAN'S NAME (Type) Rexford H. HUNT LT MG USN		22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-25-60	
23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		23d. LOCATION (City, town, or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Ives Funeral Home, 2847 Wilson Blvd, Arlington		25a. REC'D BY REGISTRAR DATE OCT 24 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Evans			



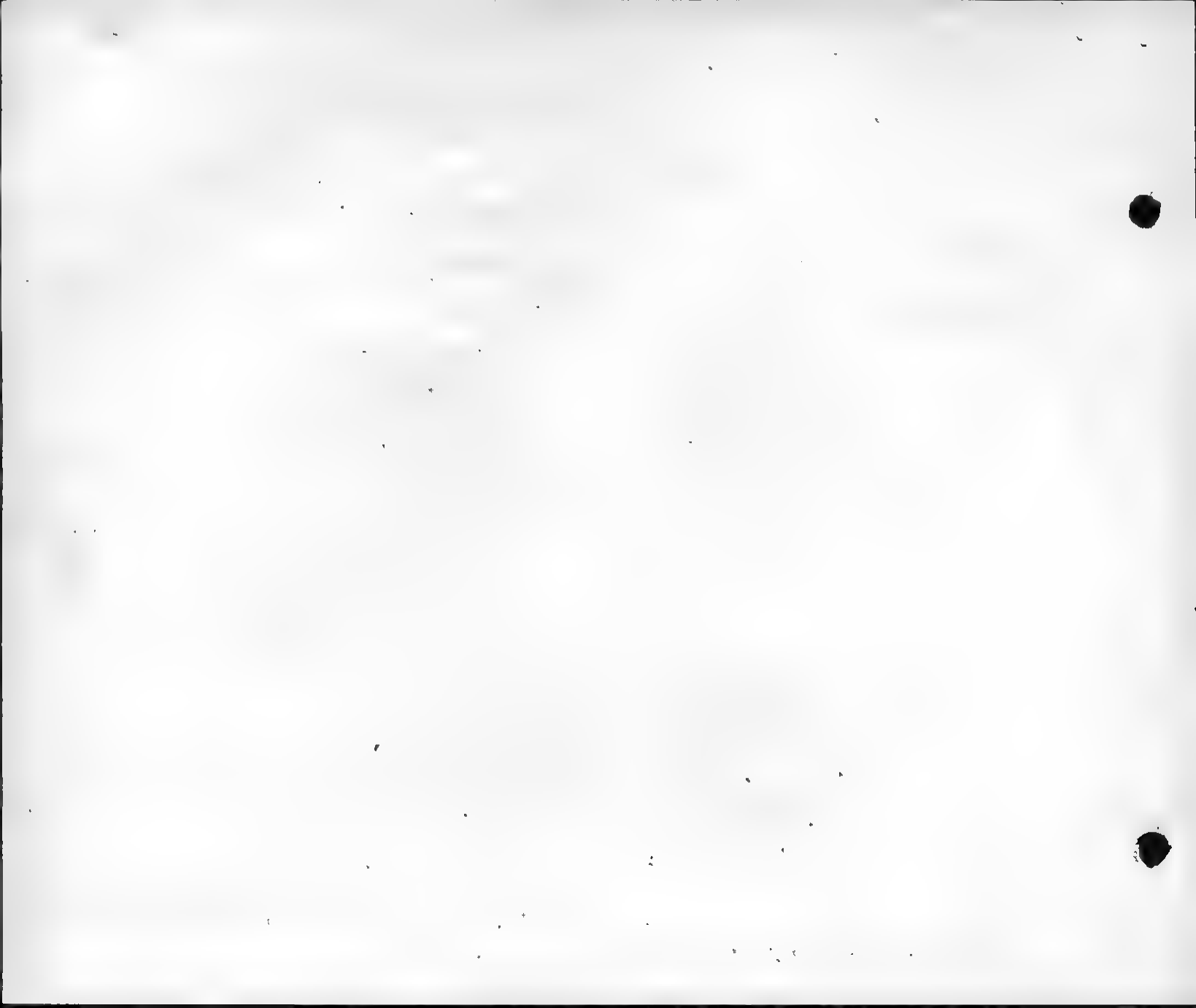
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN lb <u>1 mo - less 3 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San Hosp</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>1721 LUZERNE AVENUE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>DANA</u> Middle <u>Edmund</u> Last <u>Cheney</u>		4. DATE OF DEATH Month <u>10</u> - Day <u>5</u> - Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-24-95</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>4</u>	11. IF UNDER 24 HRS. Hours <u>6</u> Min <u>4</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>gas station attendant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mazda Bros</u>	11. BIRTHPLACE (State or foreign country) <u>NEW Hampshire</u>
12. CITIZEN OF WHAT COUNTRY? <u>U S A.</u>		13. FATHER'S NAME <u>David O. Cheney</u>	
14. MOTHER'S MAIDEN NAME <u>I. Dana</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>W. W. I.</u>	
16. SOCIAL SECURITY NO. <u>002-03-3379</u>		INFORMANT <u>Hospital Records</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma of the liver</u> 1572 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of the tail of pancreas</u> DUE TO (c) <u>6 mos.</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Subacute bacterial endocarditis</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 9, 1960</u> to <u>Oct 5, 1960</u> that I last saw the deceased alive on <u>Oct 5, 1960</u> , and that death occurred at <u>9:25 AM</u> , from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Abraham W. Danish</u> M.D.		ADDRESS (Street, city or town, state) <u>927 Berkeley St.</u> DATE SIGNED <u>10-6-60</u>	
PHYSICIAN'S NAME (Type) <u>ABRAHAM W. DANISH</u>		<u>Arthur S. Kline</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>10/7/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u>		24a. REC'D BY REGISTRAR <u>OCT 10 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11578

11509

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>R.D. 1, Gaithersburg 12 yrs.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>R.D. 1, Gaithersburg</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R.D. 1, Gaithersburg</u>				e. STREET ADDRESS <u>R.D. 1, Gaithersburg</u>			
3. NAME OF DECEASED (Type or print) <u>THOMAS Solomon Claggett</u> First Middle Last				4. DATE OF DEATH <u>Oct. 16</u> 19 <u>60</u> Month Day Year			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 4, 1883</u>	9. AGE (in years last birthday) <u>77</u> yrs	10. IF UNDER 1 YEAR: Months Days Hours		11. IF UNDER 24 HRS: Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Charles Claggett</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Mrs. Florence Claggett, wife</u> Address <u>R.D. 1, Gaithersburg</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma</u> DUE TO <u>Left, Lung field</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>IN ANITATION</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 17, 1957</u> to <u>Oct. 16, 1960</u> , that (I) (we) last saw the deceased alive on <u>Oct. 16, 1960</u> , and that death occurred <u>4:30 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Clive E. Jackson, M.D.</u> M.D.				22b. DATE SIGNED <u>Oct. 10, 60</u>			
22c. PHYSICIAN'S NAME (Type) <u>Clive E. Jackson</u>				22d. ADDRESS <u>R.D. 1, Gaithersburg</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/19/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Brooke Grove.,</u>		23d. LOCATION (City, town, or county) (State) <u>Laytonsville, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u> ADDRESS <u>Pockville, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 19 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kiana</u>	

1

Handwritten notes at the top of the page, including "1000" and "1000" written vertically.

Handwritten notes in the middle section, including "1000" and "1000" written vertically.

Handwritten notes at the bottom of the page, including "1000" and "1000" written vertically.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9-59

1

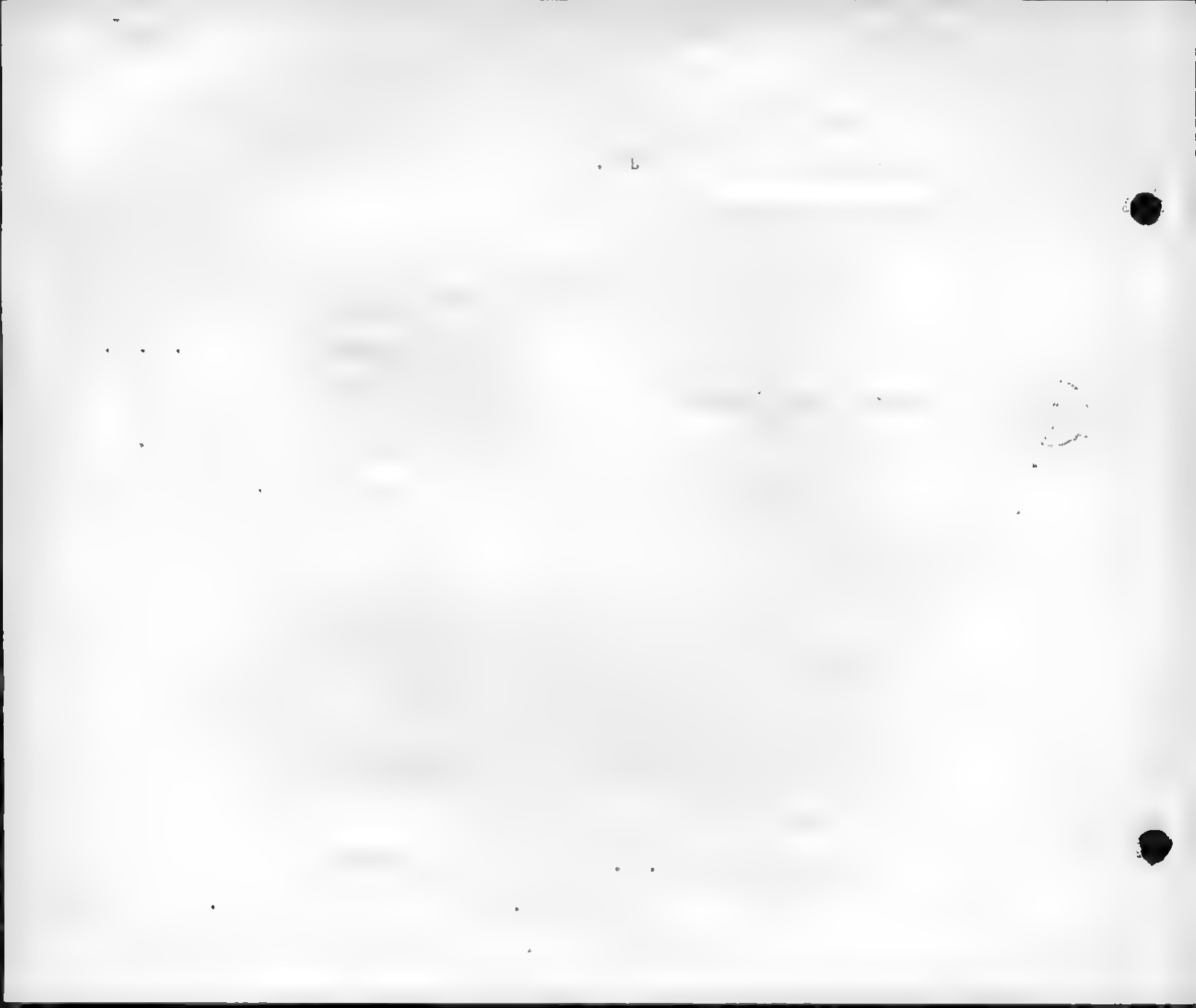
11579

DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11510

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HOWARD		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLARKSVILLE		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL			d. STREET ADDRESS 1-2-2		
3. NAME OF DECEASED (Type or print) First Middle Last DONALD COLEMAN			4. DATE OF DEATH Month Day Year OCTOBER 14 19 60		
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 14, 1960		9. AGE (in years last birthday) yrs. 5 1/2
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND
13. FATHER'S NAME RAYMOND ELWOOD COLEMAN			14. MOTHER'S MAIDEN NAME JEAN ALBA SMITH		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT HOSPITAL RECORDS,			Address OLNEY, MD.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity, Immaturity (2 lbs. 5 ounces) DUE TO (b) 776x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Oct. 14, 1960 to Oct. 14, 1960 that (I) (we) last saw the deceased alive on Oct. 14, 1960 , and that death occurred at 11 PM , from the causes and on the date stated above.					
22a. SIGNATURE OF PHYSICIAN'S NAME (Type) JACK SCHUMACHER			22b. DATE SIGNED 10.15.60		
22c. PHYSICIAN'S NAME (Type) JACK SCHUMACHER, M. D.			22d. ADDRESS GAITHERSBURG, MARYLAND		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/17/60		23c. NAME OF CEMETERY OR CREMATORY Hopkins Chapel..	
23d. LOCATION (City, town, or county) Highland, Md.		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Sumrell			ADDRESS Rockville, Md.		
25a. REC'D BY REGISTRAR OCT 18 '60			25b. REGISTRAR'S SIGNATURE Charles E. House		

227: x1 TXV1



11580

MARYLAND STATE DEPARTMENT OF HEALTH

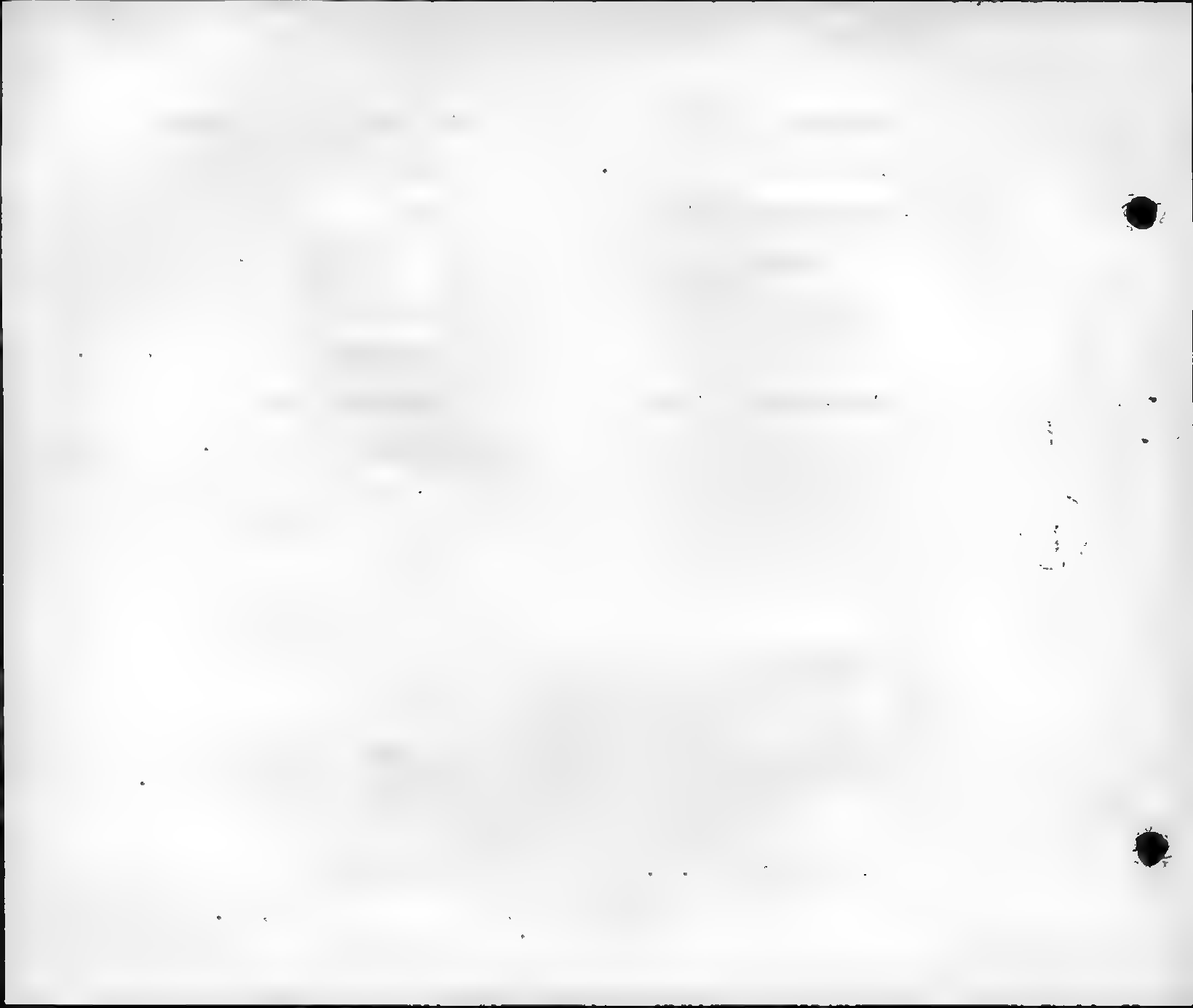
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11511

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HOWARD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. LENGTH OF STAY IN 1b 3 HRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL				d. STREET ADDRESS CLARKSVILLE			
3. NAME OF DECEASED (Type or print) First DOUGLAS Middle Last COLEMAN				4. DATE OF DEATH Month OCTOBER Day 14 Year 1960			
5. SEX MALE		6. COLOR OR RACE NEGRO		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/14/60	
9. AGE (In years last birthday) 3		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME RAYMOND ELWOOD COLEMAN		14. MOTHER'S MAIDEN NAME JEAN ALDA SMITH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT MEDICAL RECORDS, OLNEY, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, Immaturity (2 hr. 40 min.) DUE TO (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from Oct. 14 to Oct. 14 19 60 that (I) (we) last saw the deceased alive on Oct. 14 19 60 and that death occurred at 8:15 A.M. from the causes and on the date stated above							
22a. SIGNATURE Jack Schumacher				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 10.15.60	
22c. PHYSICIAN'S NAME (Type) JACK SCHUMACHER, M. D.				22d. ADDRESS GAITHERSBURG, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/17/60		23c. NAME OF CEMETERY OR CREMATORY Hopkins Chapel,		23d. LOCATION (City, town, or county) (State) Highland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Swoden				ADDRESS Rockville, Md.		25a. REC'D BY REGISTRAR DATE OCT 18 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL: The attending physician: The low requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/55

11581

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

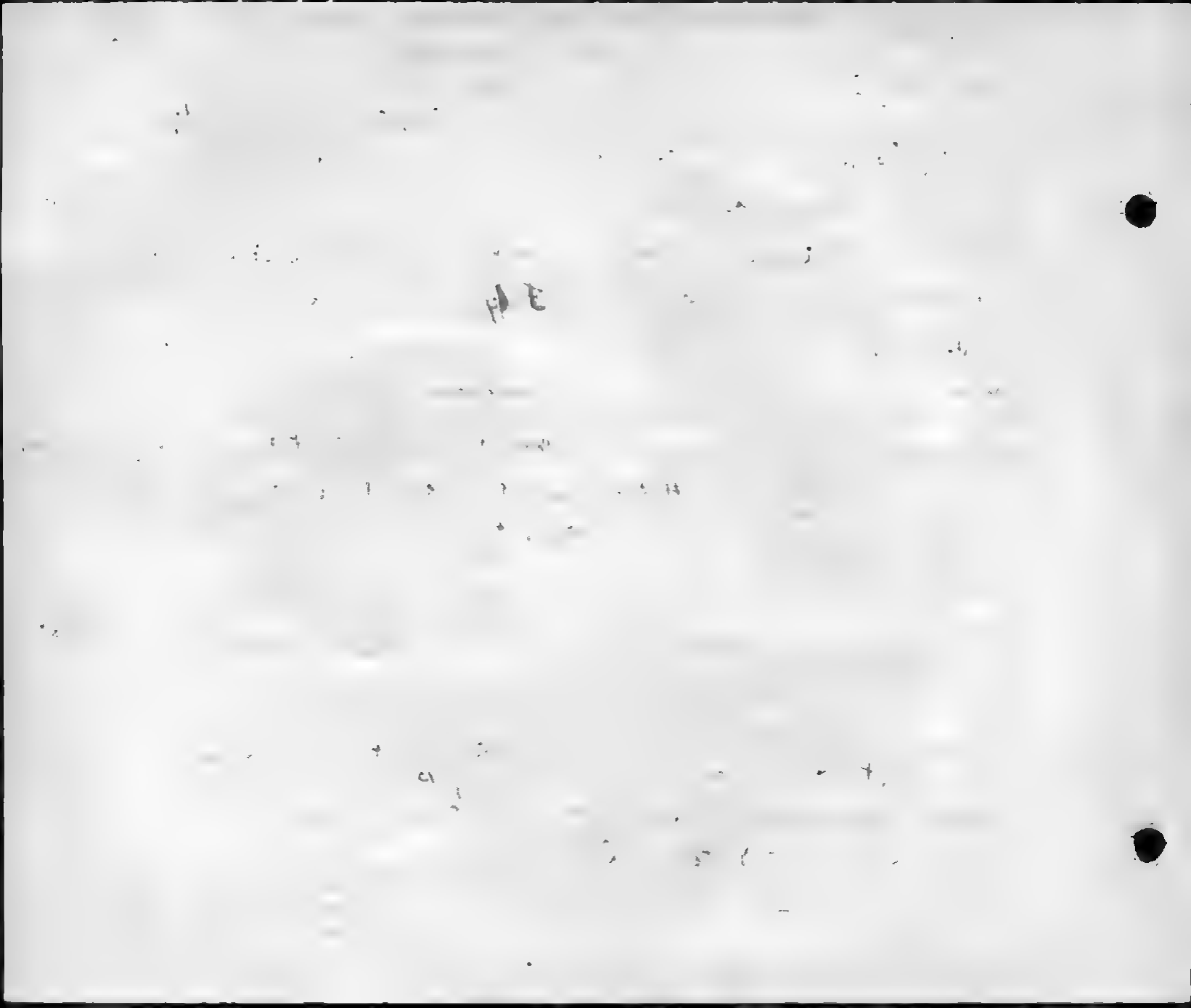
CERTIFICATE OF DEATH

11512

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Olney	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION c/o Rosa Benson Brown		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First Mamie Middle unknown Last Cook		4. DATE OF DEATH Month October Day 22 Year 1960	
5. SEX Female	6. COLOR OR RACE Wh.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 15, 1879
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Virginia ?		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. —	
17. INFORMANT Mrs. Rosa Benson Brown Address Sandy Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Senility Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO (c) —		INTERVAL BETWEEN ONSET AND DEATH 3 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1958 to Oct. 1960 , that I last saw the deceased alive on Oct 14 , 1960, and that death occurred at 7:15 P.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) Olney, Md. DATE SIGNED 10-22-60 ACTUAL SIGNATURE Richard A. Yates M.D. PHYSICIAN'S NAME (Type) Richard A. Yates M.D.			
22a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) Burial	22b. DATE THEREOF 10-25-60	22c. NAME OF CEMETERY OR CREMATORY Flint Hill	22d. LOCATION (City, town, or county) (State) Oakton Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber ADDRESS Laytonsville, Md.		24a. REC'D BY REGISTRAR OCT 31 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kenna

MEDICAL CERTIFICATION

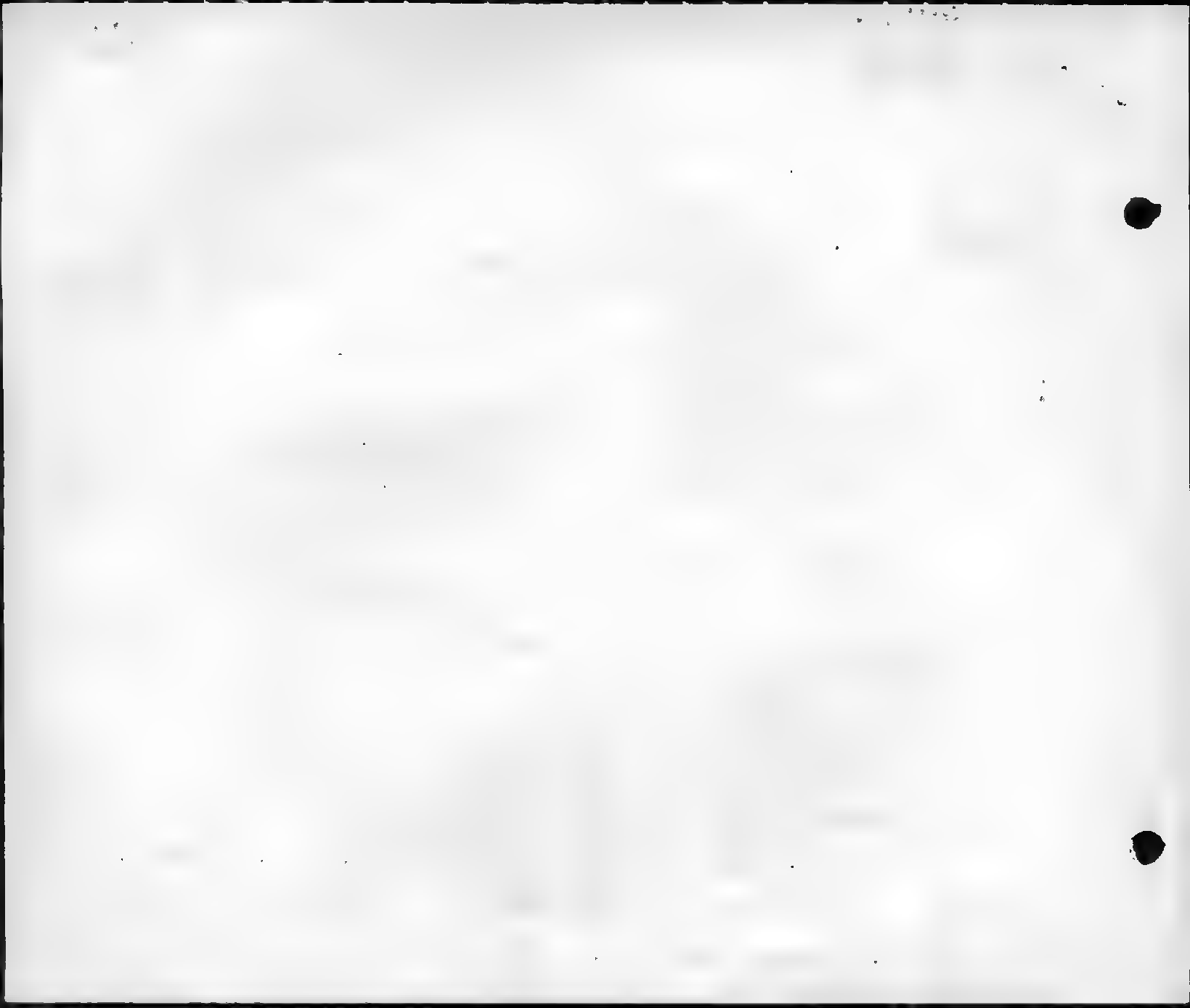


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be re-submitted by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
11582
11513
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>today</i>		X CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban Hospital</i>				d. STREET ADDRESS <i>RED 3, zone 14 Bethesda</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Boulah Frances COOLEY</i>				DATE OF DEATH Month Day Year <i>October 19 1960</i>			
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>September 25 1902</i>	
9. AGE (In years last birthday) <i>58 yrs</i>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Thomas E Bissett</i>				14. MOTHER'S MAIDEN NAME <i>Nancy W Kitchen</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>No</i>		17. INFORMANT Address <i>Charles L. Cooley RFD 3, zone 14 Bethesda</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebro-Vascular Occlusion</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Jan 1957</i> to <i>OCT 17 1960</i> that (I) (we) last saw the deceased alive on <i>10-17 1960</i> and that death occurred at <i>10-19-60</i> M, from the causes and on the date stated above							
22a. SIGNATURE <i>Paul D. Cantor M.D.</i>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>10-19-60</i>	
22c. PHYSICIAN'S NAME (Type) <i>Paul D. Cantor</i>				22d. ADDRESS <i>4709 Montg. Lane, Bethesda, Md</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>10/22/60</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Monocacy Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Beallsville, Maryland</i>	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Robert A. Pumphrey Bethesda, Maryland</i>				25a. REC'D BY REGISTRAR DATE <i>OCT 21 '60</i>		25b. REGISTRAR'S SIGNATURE <i>Charles L. Pumphrey</i>	



1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division 3 STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11507

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Potomac</u> c. LENGTH OF STAY IN TB <u>6 mo</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Ropine Nursing Home</u>					2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>md</u> b. COUNTY <u>P. G.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Morningside</u> d. STREET ADDRESS <u>21 Bicket Dr</u>						
3. NAME OF DECEASED (Type or print) <u>Elsie I Castello</u>					4. DATE OF DEATH <u>Oct 18 1960</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-1-85</u>		9. AGE (In years last birthday) <u>75</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (State or foreign country) <u>Wadsworth, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Unknown</u>					14. MOTHER'S MAIDEN NAME <u>Unknown</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>None</u>					17. INFORMANT <u>Nursing Home Record</u> Address <u>-----</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) <u>-----</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>-----</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Frank died in bed</u>						
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-----</u>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-----</u>						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-----</u>		20f. (City or town) <u>-----</u> (County) <u>-----</u> (State) <u>-----</u>					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Frank J. Broschauer</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type) <u>FRANK J Broschauer</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>10-18-60</u>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/22/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>		22d. LOCATION (City, town, or country) (State) <u>Silver Spring, Maryland</u>					
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>					24a. REC'D BY REGISTRAR <u>OCT 24 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>				

MEDICAL CERTIFICATION

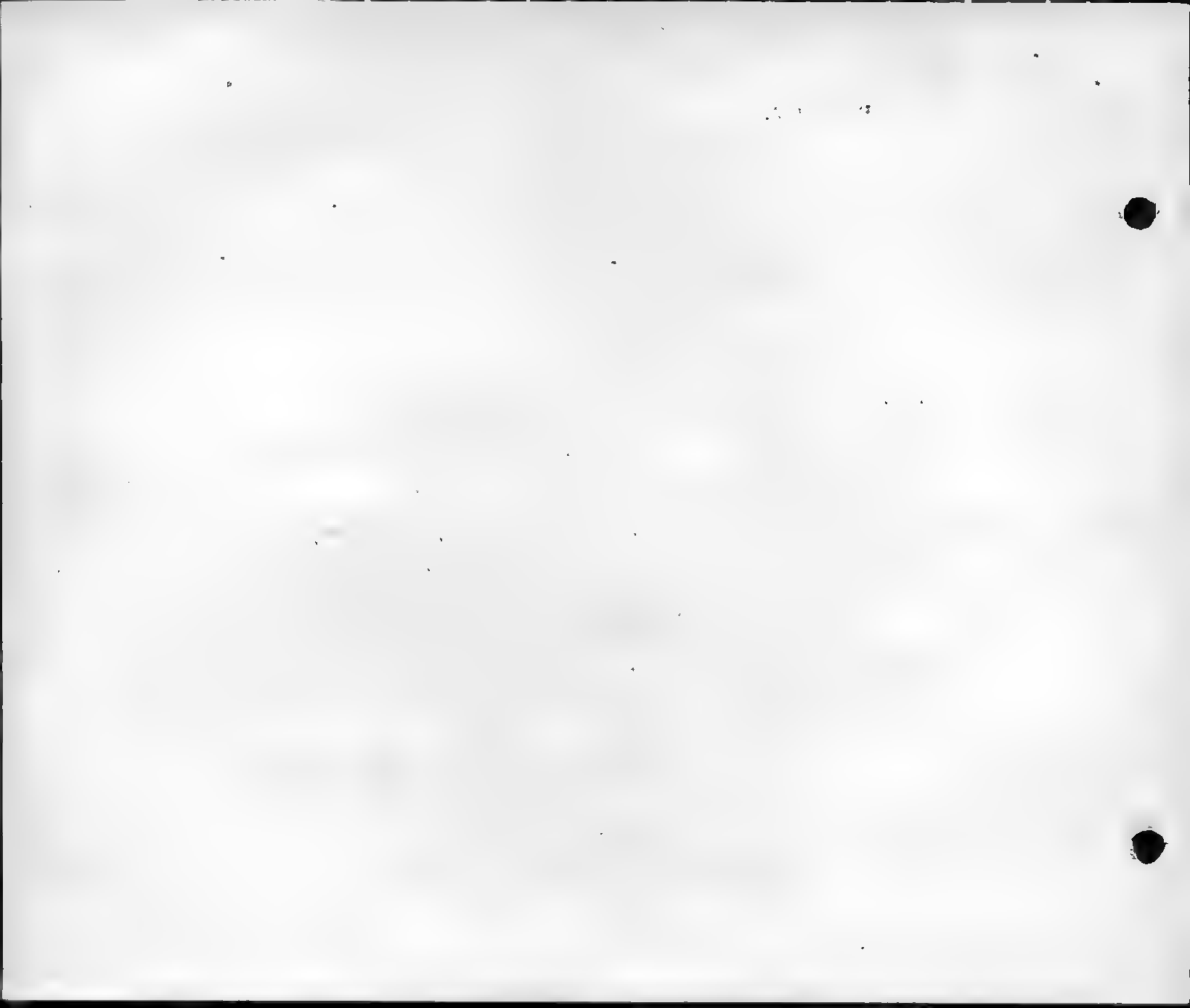


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										
11583										
11514										
CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda					c. LENGTH OF STAY IN 1b					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital					e. STREET ADDRESS 206 Shaw Ave.					
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) First MARGARET Middle E. Last COUNSELMAN					4. DATE OF DEATH Month Oct. Day 19 Year 1960					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/29/1879		9. AGE (In years last birthday) 80 yrs		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none-Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Wm. H. Green					14. MOTHER'S MAIDEN NAME Katherine Coffey					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO no		17. INFORMANT Son		Address Roy Counselman 206 Shaw Ave., Silver Sp., Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]										
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) HYPOSTATIC PNEUMONIA, BILATERAL										
600.0 DUE TO (b) DEBILITATION, MALNUTRITION,										
DUE TO (c) PYELO NEPHROSIS, SEPTICEMIA										
INTERVAL BETWEEN ONSET AND DEATH 2 days 2 1/2 mos. 2 1/2 mos										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) FRACTURE RT. FEMUR 3 1/2 MO. 1960										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
MEDICAL CERTIFICATION										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) FELL DURING DIZZY SPELL IN KITCHEN AT HOME					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day Year 10 JUL 31 1960					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>					
20e. PLACE OF INJURY Home, farm, factory, street, office bldg. etc.) HOME					20f. (City or town) SILVER SPRING, MD (County) MONTGOMERY (State)					
21. I certify that (I) (this hospital) attended the deceased from MAR 1955 to 19 OCT 1960 that (I) last saw the deceased alive on 19 OCT 1960 , and that death occurred at 6:50 P M, from the causes and on the date stated above										
22a. SIGNATURE Marshall Cuvillier Jr. MD					22b. DATE SIGNED 20 OCT 1960					
22c. PHYSICIAN'S NAME (Type) LI MARSHALL CUVILLIER JR. MD					22d. ADDRESS 1407 WOODSIDE PKWY SILVER SPRING, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/24/60		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) (State) Suitland, Maryland				
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey					ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE OCT 21 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

I

074



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

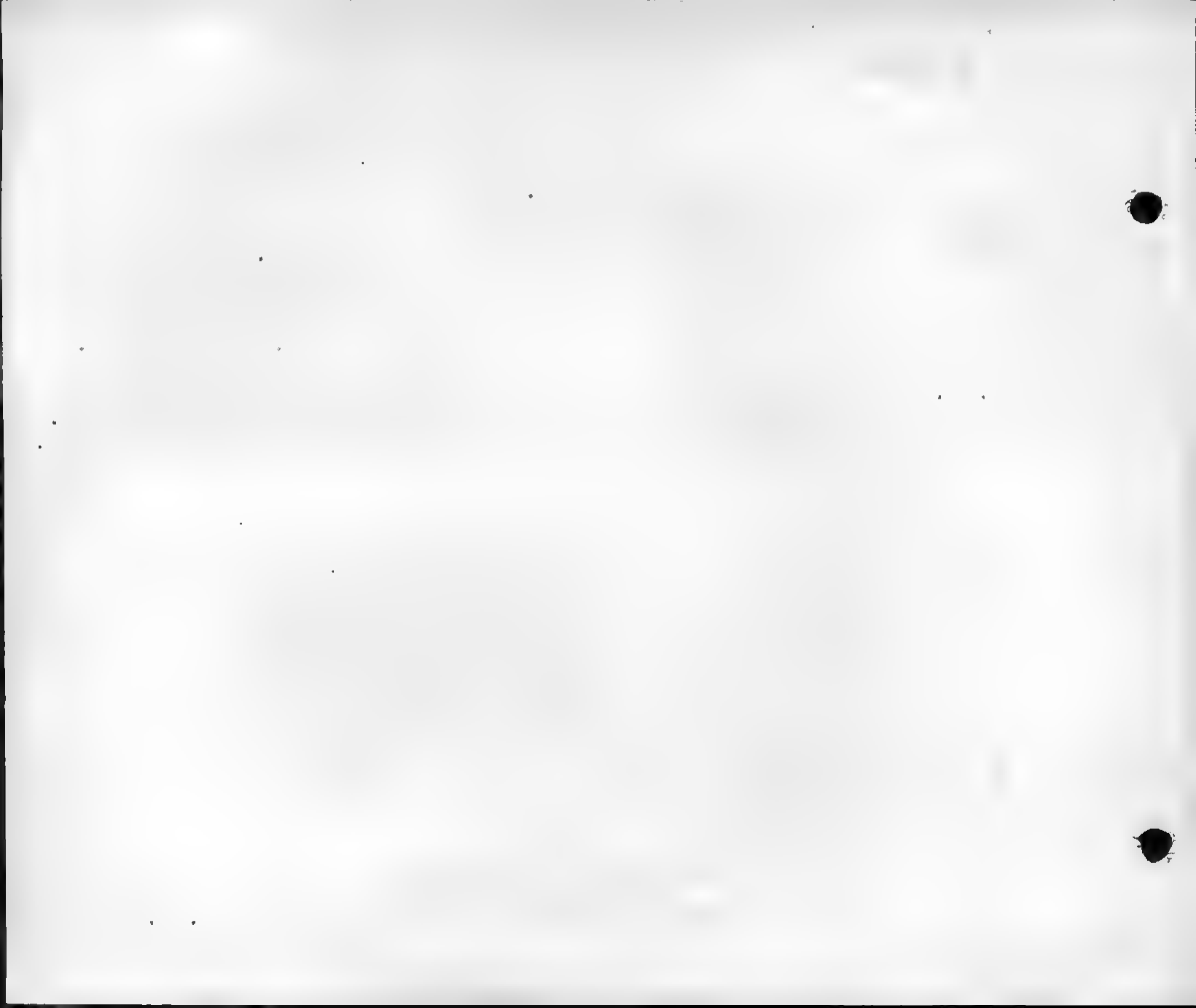
1

11584

11515

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase, Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9200 Old Georgetown Rd. Alta Vista Nursing Home		d. STREET ADDRESS 4709 Morgan Drive 9200202	
3. NAME OF DECEASED (Type or print) Berdie Hough Crawford		4. DATE OF DEATH Oct. 29 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/19/1874
9. AGE (In years lost birthday) 86		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME W. W. Hough		14. MOTHER'S MAIDEN NAME Jane Robinson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Miss Jane E. Crawford		18. ADDRESS 4709 Morgan Dr. Chevy Chase, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 350X Coronary Artery Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis with Parkinsonism (c)		INTERVAL BETWEEN ONSET AND DEATH sudden years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Compression Fracture of Lumbar Vertebra 9/27/60			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from January 1954 to Oct 27, 1960 , that (I) (we) last saw the deceased alive on Oct 27, 1960 , and that death occurred at AM , from the causes and on the date stated above			
22a. SIGNATURE Robert B. Have		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Robert B. Have / M.D.		22d. ADDRESS 5516 Nebraska Ave. DC	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/1/60	
23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION (City, town, or county) (State) Washington, D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE Charles N. Have		25. REC'D BY REGISTRAR DATE OCT 31 '60	
26. ADDRESS 2901-24th St. WASH D.C.		25b. REGISTRAR'S SIGNATURE Arthur S. Finner	



11522

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution - Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>11611 Dewey Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Paul David Crothers</u> Fiat Middle Lost		4. DATE OF DEATH <u>October 8, 1960</u> Month Day Year			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 7, 1960</u>	9. AGE (In years last birthday) <u>-</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Paul David Crothers</u>		14. MOTHER'S MAIDEN NAME <u>Maudie Mae McConnell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>FATHER</u> Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>776x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <u>9 1/2 hrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/7/60</u> , 19, to <u>10/8/60</u> , 19, that I last saw the deceased alive on <u>10/7/60</u> , 19, and that death occurred at <u>7:35 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE <u>A. W. Smith</u>		M.D. <u>13018 GEORGIA AVE.</u>			
PHYSICIAN'S NAME (Type) <u>A. W. SMITH</u>		WHEATON, MD.			
22a. BURIAL CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Cremation</u>	<u>10-10-60</u>	<u>Washington San & Hospital - Takoma Park Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
<u>Robert A. Hagg, M.D.</u>		<u>Washington San & Hospital</u>		<u>13 '60</u>	

TO HOSPITAL BY ATTENDING PHYSICIAN; The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11585

1
M
7

1
1

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11517

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 4 days 2 hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery General Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg			
				d. STREET ADDRESS 14 Chesnut Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Agnes Middle Roberta Last Crown				4. DATE OF DEATH Month October Day 1 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 24, 1872		9. AGE (In years last birthday) 88 yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME John Small				14. MOTHER'S MAIDEN NAME Annie Fleming			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 170X IMMEDIATE CAUSE (a) malignancy of right lung first seen DUE TO (b) malignancy of left breast - first seen Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 9-20-60 OCT-26-1960	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from OCT-26-1957 to OCT-1-1960 that (I) (we) last saw the deceased alive on OCT-1-1960 , and that death occurred at P. M. from the causes and on the date stated above.							
22a. SIGNATURE William C. Miller		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) William C. Miller		22d. ADDRESS 7 Brooks Avenue, Gaithersburg, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-4-60		23c. NAME OF CEMETERY OR CREMATORY Forest Oak		23d. LOCATION (City, town, or county) (State) Gaithersburg Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner.				ADDRESS Gaithersburg Md.		25a. REC'D BY REGISTRAR DATE OCT 4 '60	
				25b. REGISTRAR'S SIGNATURE C. Stuart G. Kunk			

Handwritten text, possibly a signature or date, appearing upside down.

Handwritten text, possibly a date or reference number.

Handwritten text, possibly a date or reference number.

Handwritten text, possibly a date or reference number.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11523

CERTIFICATE OF DEATH

Reg. Dist. No.

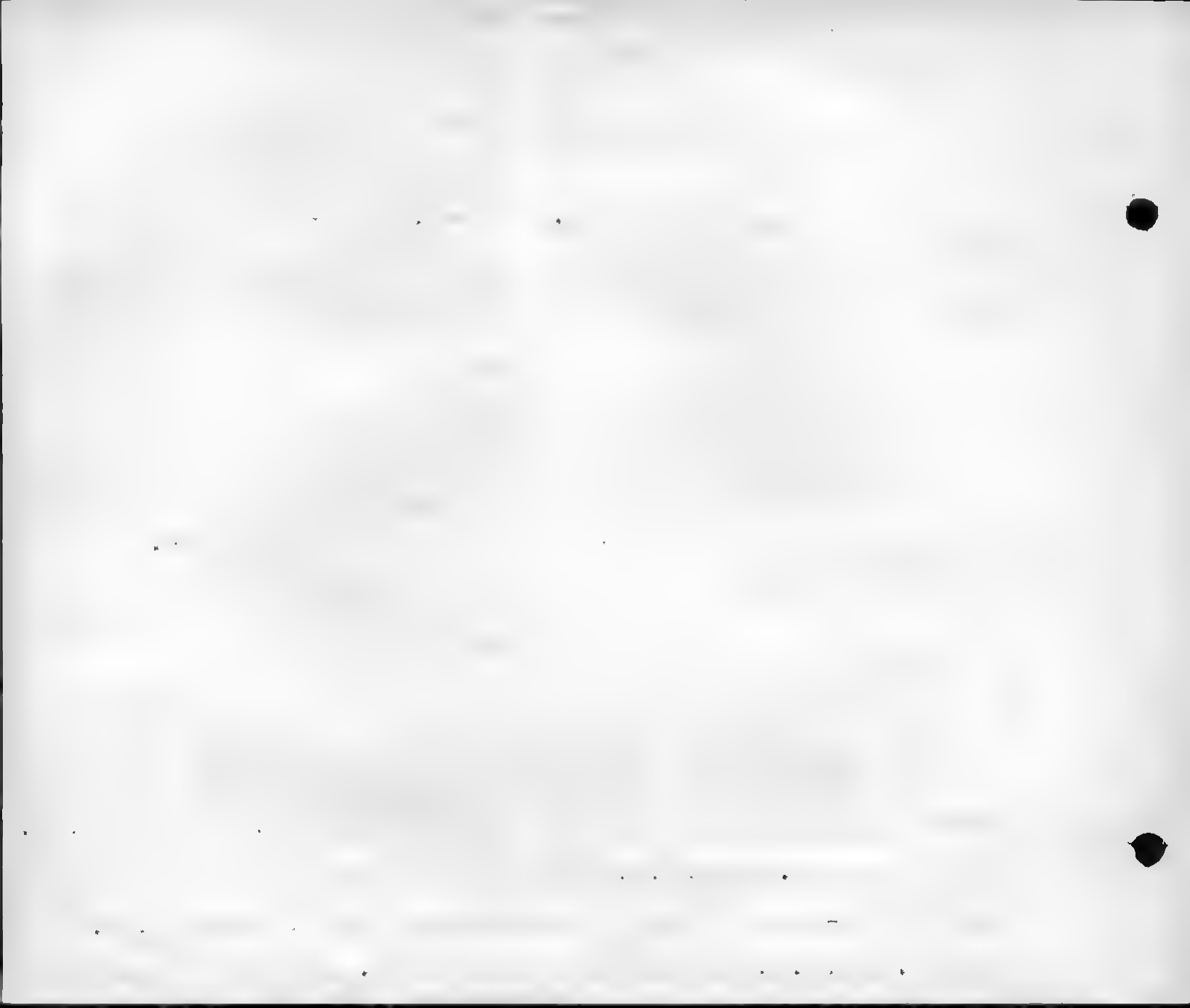
14560

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before adm'ss on) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hosp.</u>				d. STREET ADDRESS <u>Route 3, Box 141-B</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Tosant Culbertson</u>				4. DATE OF DEATH Month <u>10</u> Day <u>31</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-31-60</u>	
9. AGE (In years last birthday) <u>1</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>18</u>		IF UNDER 24 HRS Hours <u>1</u> Min. <u>18</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>Paul Trauger Culbertson Jr.</u>				14. MOTHER'S MAIDEN NAME <u>Ruth Juanita Whitley</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mother's Chart</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anoxia due to pulmonary hypoplasia</u>							
754-2 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) <u>Cardiac interventricular membranous septal defect.</u>							
DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-31</u> 19 <u>60</u> , to <u>10-31</u> 19 <u>60</u> , that I last saw the deceased alive on <u>10-31</u> 19 <u>60</u> , and that death occurred at <u>2:48</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles B. Hughes</u>				ADDRESS (Street, city or town, state) <u>911 Silver Spring Ave., Silver Spring, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Charles B. Hughes, M.D.</u>				DATE SIGNED <u>same as above</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>10-31-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium and Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Takoma Park, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Hare, M.D.</u>				ADDRESS <u>Washington Sanitarium & Hospital</u>		24a. REC'D BY REGISTRAR <u>DEC 8 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hare</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT.

(M)

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
11524											
11518											
1. PLACE OF DEATH a. COUNTY Montgomery				b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park				c. LENGTH OF STAY IN b D O A			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium Hosp				e. STATE Maryland				f. COUNTY Prince George's			
2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Add West Hyattsville				b. STREET ADDRESS 2411 Lewisdale Dr.				c. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) James Bernard Curtin				4. DATE OF DEATH 10-30-60				5. AGE (in years last birthday) 42			
6. COLOR OR RACE M W				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 2-4-1918			
9. AGE (in years last birthday) 42				10. IF UNDER 1 YEAR Months Days				11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman				10b. KIND OF BUSINESS OR INDUSTRY D.C.				11. BIRTHPLACE (State or foreign country) Wash D.C.			
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Charles O. Curtin				14. MOTHER'S MAIDEN NAME Anna Meikel			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes Army 40-45				16. SOCIAL SECURITY NO. Mrs. Doris Curtin				17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420-1 Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): History of previous heart attacks				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH 3 1/2 hrs.			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE NAME (Type) Frank J. Brosch				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 10-30-60				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 11/2/60				22c. NAME OF CEMETERY OR CREMATORY Cedar Hill			
22d. LOCATION (City, town, or country) (State) Suitland, Md.				23. FUNERAL DIRECTOR Halley's Funeral Home, McLean, Md. Inc.				24a. REC'D BY REGISTRAR DATE NOV 2 '60			
24b. REGISTRAR'S SIGNATURE Arthur E. Frank											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)
15M 9/59

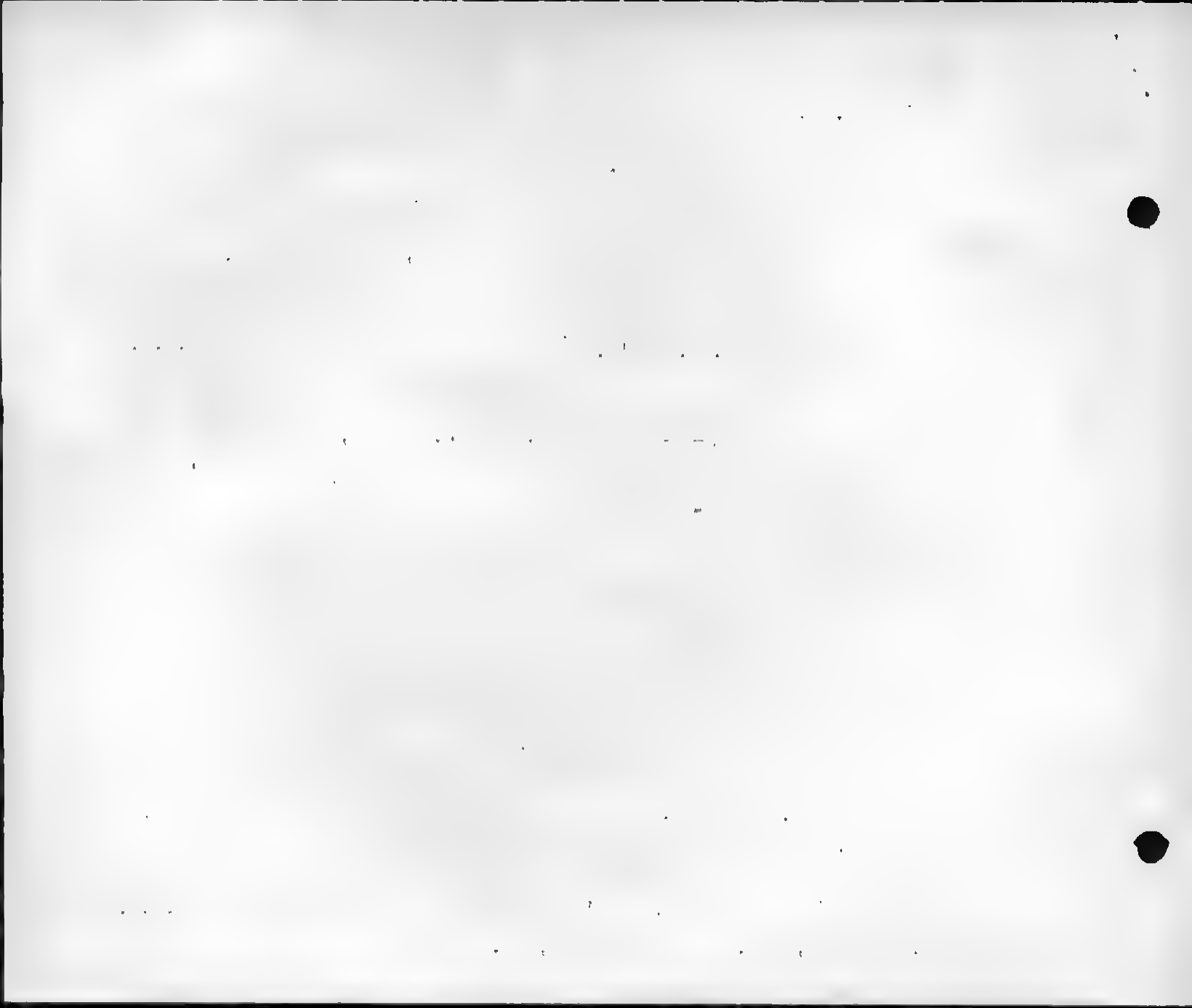
DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11519

11505

1. PLACE OF DEATH o COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			
c. LENGTH OF STAY IN 1b 3 yrs.				d. STREET ADDRESS 1706 GRIDLEY LANE			
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION 1706 GRIDLEY LANE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JAMES Middle FRANCIS Last DALTON, SR				4. DATE OF DEATH Month OCT. Day 6 Year 1960			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/8/79	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Mm.		IF UNDER 24 HRS Months Days Hours Mm.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Construction Engineer				10b. KIND OF BUSINESS OR INDUSTRY D. C. Gov't.		11. BIRTHPLACE (State or foreign country) IRELAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME PATRICK DALTON				14. MOTHER'S MAIDEN NAME ELIZA GREY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 678-32-6962		17. INFORMANT Mrs. Mary E. Dalton, 1706 Gridley Lane	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral arteriosclerosis 334X DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) Generalized arteriosclerosis				19. INTERVAL BETWEEN ONSET AND DEATH Years Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1961 to Oct. 6 1960 , that (I) (we) last saw the deceased alive on Oct 6 1960 , and that death occurred at 11 PM , from the causes and on the date stated above							
22a. SIGNATURE Abraham W. Davis				22b. DATE 10-7-60			
22c. PHYSICIAN'S NAME (Type) ABRAHAM W. DAVIS				22d. ADDRESS 917 Pessing Dr. Silver Spring, Md.			
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/10/60		23c. NAME OF CEMETERY OR CREMATORY ST. JOHN'S CEMETERY		23d. LOCATION (City town or county) (State) MONTGOMERY COUNTY, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC.				ADDRESS SILVER SPRING, MD.		25a. REC'D BY REGISTRAR OCT 11 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Frank							

M



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
FOR STATE
HEALTH DEPT.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11520											
1. PLACE OF DEATH e. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>N.J.</u> b. COUNTY <u>6/1X</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>				c. LENGTH OF STAY IN 1b <u>10 days</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>River Edge</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>11419 Newport Mill Rd</u>				d. STREET ADDRESS <u>184 Oxford Ter.</u>				9. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Eloise Marie Daly</u>				4. DATE OF DEATH <u>Oct 19 1960</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-1-1893</u>		9. AGE (in years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>				11. BIRTHPLACE (State or foreign country) <u>Ila.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Pierce</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Pierce</u>				16. SOCIAL SECURITY NO. <u>huchee Daly - Stem</u>				17. INFORMANT <u>Powers</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a); 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) DATE SIGNED <u>10-19-60</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. & BURIAL</u>				22b. DATE THEREOF <u>10/24/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Hackensack, Bergen County, N.J.</u>			
23. FUNERAL DIRECTOR <u>WARNER E. PUMPHREY, INC.</u>				ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REG. STRAR DATE <u>OCT 21 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	



11587

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11521

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Echo Heights		
c. LENGTH OF STAY IN 1b 1 day			d. STREET ADDRESS 6007 Namakagan Road		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Norman Francis Denis			4. DATE OF DEATH October 28, 1960		
5. SEX M			6. COLOR OR RACE W		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH September 7, 1894		
9. AGE (In years last birthday) 66 yrs			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		
11. BIRTHPLACE (State or foreign country) Woonsocket, Rhode Is.			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Alfred Denis			14. MOTHER'S MAIDEN NAME Ursula Smith		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes last U.S.			16. SOCIAL SECURITY NO. 377-09-3033		
17. INFORMANT Norma Denis			Address 6 Russell Rd. Bethesda, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive Coronary Occlusion					24 hrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)					
(c)					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (the hospital) attended the deceased from 6:30 PM 10-28, 1960 to 11:20 PM 10-28, 1960 , that (I) last saw the deceased alive on 10-28-1960 , and that death occurred at 11:20 PM , from the causes and on the date stated above.					
22a. SIGNATURE Edward Lewis, Jr. MD			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) EDWARD LEWIS, JR. MD			22d. ADDRESS 5800 PEEBLY AVE, BETHESDA, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL		2 Nov 1960		ARLINGTON NATIONAL CEMETERY	
				ARLINGTON VA.	
24. FUNERAL DIRECTOR'S SIGNATURE DeVol Funeral Home			25a. REC'D. BY REGISTRAR NOV 2 60		
ADDRESS 2224 Wisc Ave. NE Wash DC.			25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR
HEALTH

death. If any delay is necessary,
and 3 to the funeral director. Page
may be retained for your files.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours
please execute the certificate, writing the word "pending" in pencil in Item 18. Give Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. P

VS. A15.
SM 7/1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11525

11522

PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

c. LENGTH OF STAY IN 1b

Takoma Park Md. 2 1/2 hrs.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Washington Sam + Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)

a. STATE

b. COUNTY

D.C.

D.C.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Washington D.C.

d. STREET ADDRESS

648 9th St. NE

e. IS RESIDENCE ON A FARM?
YES ☐ NO ☒

3. NAME OF CEASED (or print)

5. SEX

F

6. COLOR OR RACE

C

7. MARRIED

☒ NEVER MARRIED ☐

8. DATE OF BIRTH

6-10-36 34 yrs.

9. AGE (In years last birthday)

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months Days Hours Min.

10- 26 1960

10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired)

domestic

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Alabama

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

George

14. MOTHER'S MAIDEN NAME

Lillie M. McCoy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

NO

16. SOCIAL SECURITY NO.

577-48-0500

17. INFORMANT

Bertha Mae McCoy

Address 648 9th St. NE D.C.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)

434 J

DUE TO

Acute congestive heart failure

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

INTERVAL BETWEEN ONSET AND DEATH

2 1/2 hrs

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

Hour a.m. p.m.

19

While at work ☐ Not While at work ☐

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL SIGNATURE

Frank J. Broschant

M.D.

EXAMINER'S NAME (Type)

FRANK J. Broschant

Address (Street, city, town, or county)

10-26-60

22a. BURIAL, CREMATION, REMOVAL (Specify)

burial

22b. DATE THEREOF

11/1/60

22c. NAME OF CEMETERY OR CREMATORY

Woodlawn Cemetery

22d. LOCATION (City, town, or country)

Washington

(State)

D.C.

FUNERAL DIRECTOR

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

Funeral Home 412 H St. N.E.

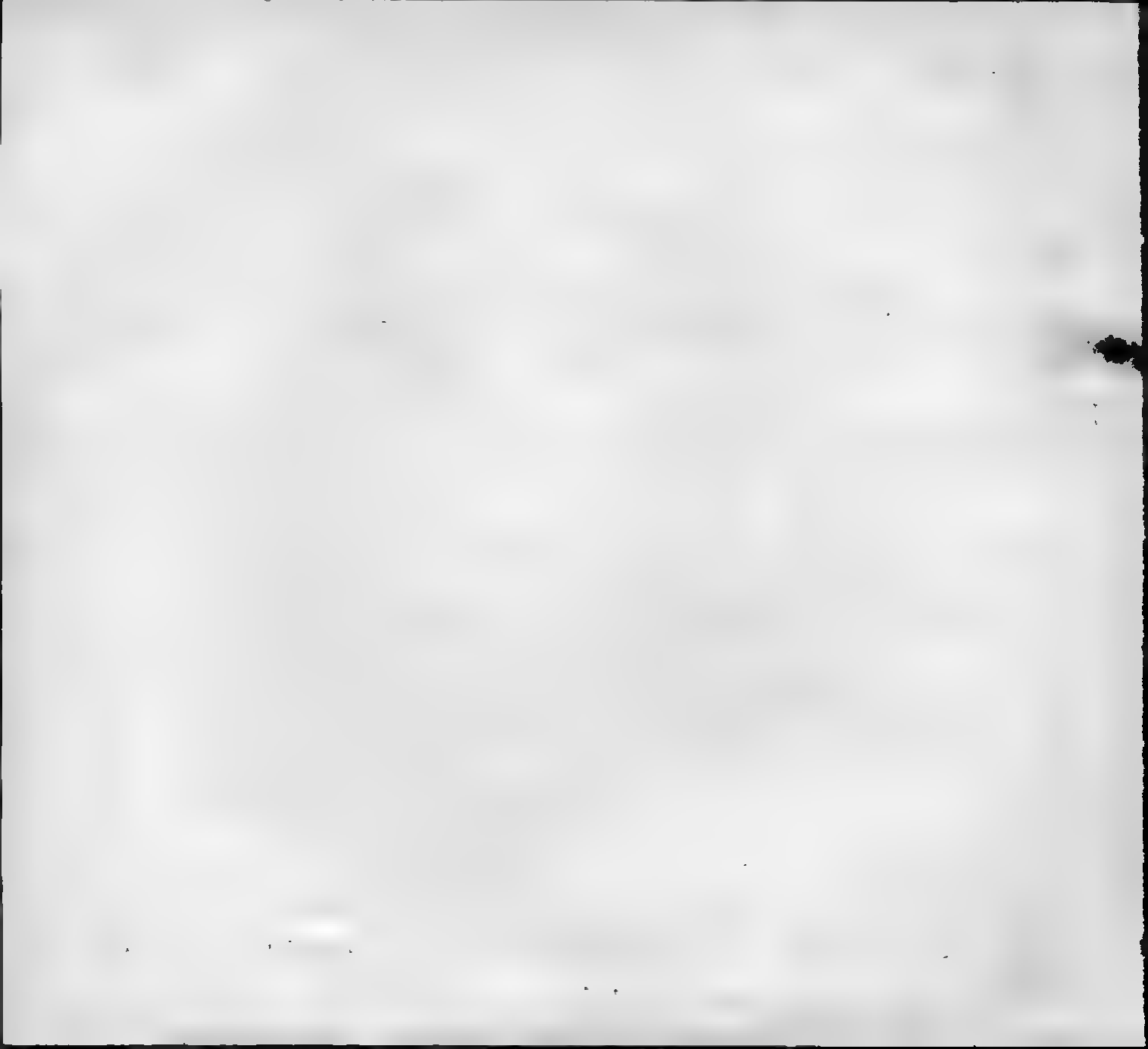
DATE OCT 31 '60

Arthur S. Evans

Washington D.C. By E. J. Murray 495

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 or its designated agent, prior to burial, cremation, or removal, and in any event within 2 with the State Board of Health 48 hours after death.

MEDICAL CERTIFICATION



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation or removal and return event within 72 hours after death.

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11523		Item 8		10-21-60 et		11523	
1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Tokoma Park		c. LENGTH OF STAY IN 1b D. O. A.		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
d. NAME OF HOSPITAL (If not in hospital, give street address and INSTITUTION) Washington San Hospital		e. STREET ADDRESS 8209 14th Avenue		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Romeo Etienne David		4. DATE OF DEATH Month Oct Day 12 Year 1960		5. SEX M		6. COLOR OR RACE W	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1882		9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Hull, Quebec, Canada		12. CITIZEN OF WHAT COUNTRY? Amer.	
13. FATHER'S NAME Stephan David		14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO	
17. INFORMANT Eunice E. Coxon		Address 8209 14th Ave. Hyattsville Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO 420 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) ARTERIOCLEROTIC HT DIS EASE DUE TO GENERALIZED ARTERIOCLEROSIS (c) 3 YEARS 7-F YRS		INTERVAL BETWEEN ONSET AND DEATH 4 WEEKS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) —	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 20 19 60 , to OCT 12 19 60 , that (I) (we) last saw the deceased alive on 10/11 19 60 , and that death occurred at 4:50 PM , from the causes and on the date stated above.							
22a. SIGNATURE Charles J. Furling		M. D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. ADDRESS 13524 University Blvd, Hyattsville, Md.		22c. PHYSICIAN'S NAME (Type) DR. CHARLES J. FURLING M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 10/14/60		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Crematory		23d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE F. Macchio Sons		ADDRESS 4735 Baltimore Ave. Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE OCT 17 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraw	

MEDICAL CERTIFICATION



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

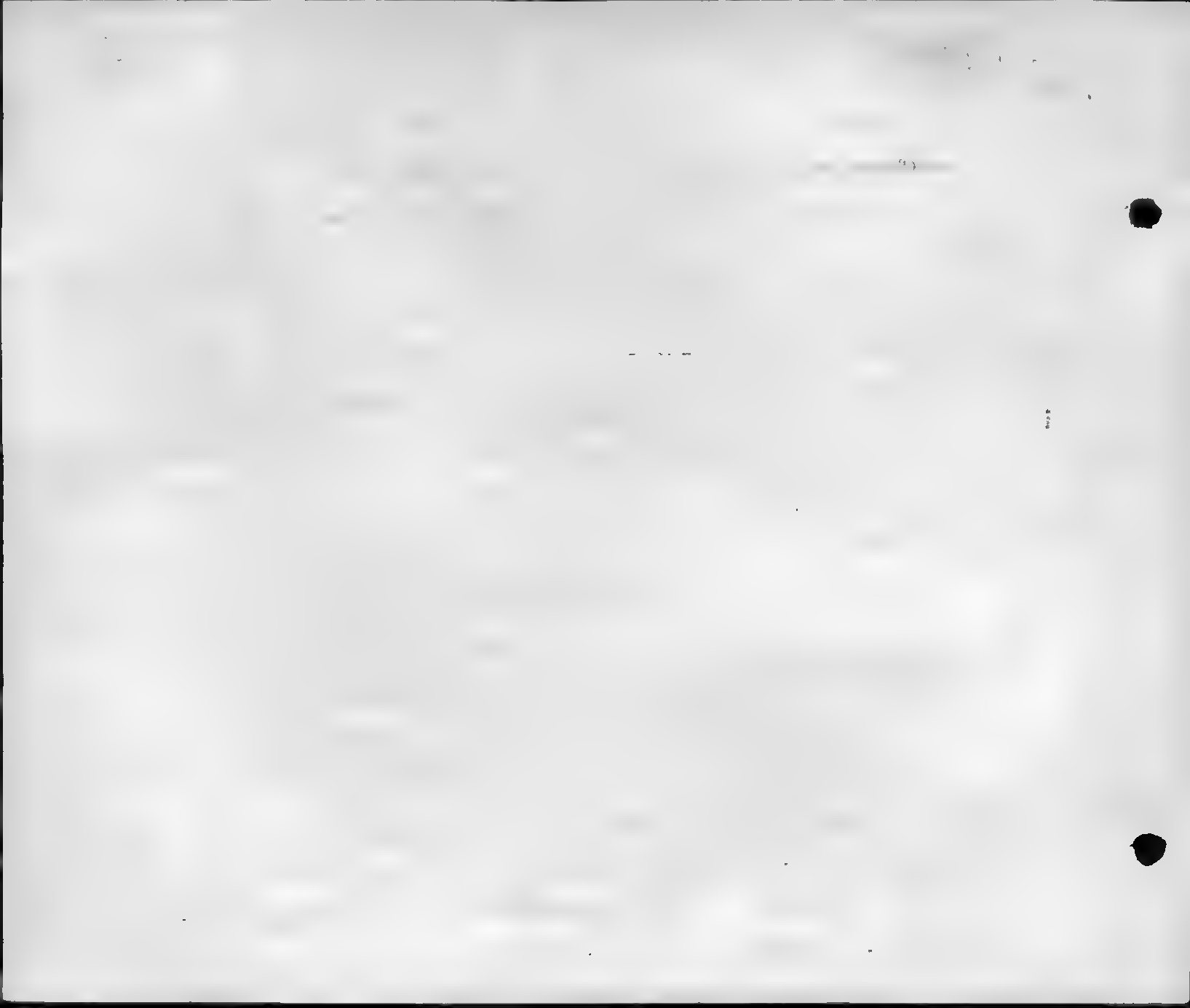
VS. A15ME
5M 7/59

M

I

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
11547											
11524											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admittance) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>					
c. LENGTH OF STAY IN TB						d. STREET ADDRESS <u>2915 Greenvale Street</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Mary K Delp</u>						4. DATE OF DEATH <u>October 3 19 60</u>					
5. SEX <u>Female</u>						6. COLOR OR RACE <u>White</u>					
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH <u>12/1/1909</u>					
9. AGE (In years last birthday) <u>50</u> yrs.						10. IF UNDER 1 YEAR Months <u>10</u> Days <u>0</u>					
11. IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>						12. CITIZEN OF WHAT COUNTRY? <u>US</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>						11. BIRTHPLACE (State or foreign country) <u>California</u>					
13. FATHER'S NAME <u>Unknown</u>						14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						16. SOCIAL SECURITY NO. <u>None</u>					
17. INFORMANT <u>Dewain L Delp-Husband-same 2d</u>						Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 1720-1 Conditions, if any, which gave rise to immediate cause (b) <u>1720-1</u> (c) <u>1720-1</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1720-1</u>						INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>11</u> p.m. <u>20</u>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Frank J. Broschart</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>						DATE SIGNED <u>10-3-60</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						22b. DATE THEREOF <u>10/5/60</u>					
22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>						22d. LOCATION (City, town, or country) (State) <u>Silver Spring, Maryland</u>					
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>						ADDRESS <u>Bethesda, Maryland</u>					
24a. REC'D BY REGISTRAR <u>OCT 5 '60</u>						24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11588

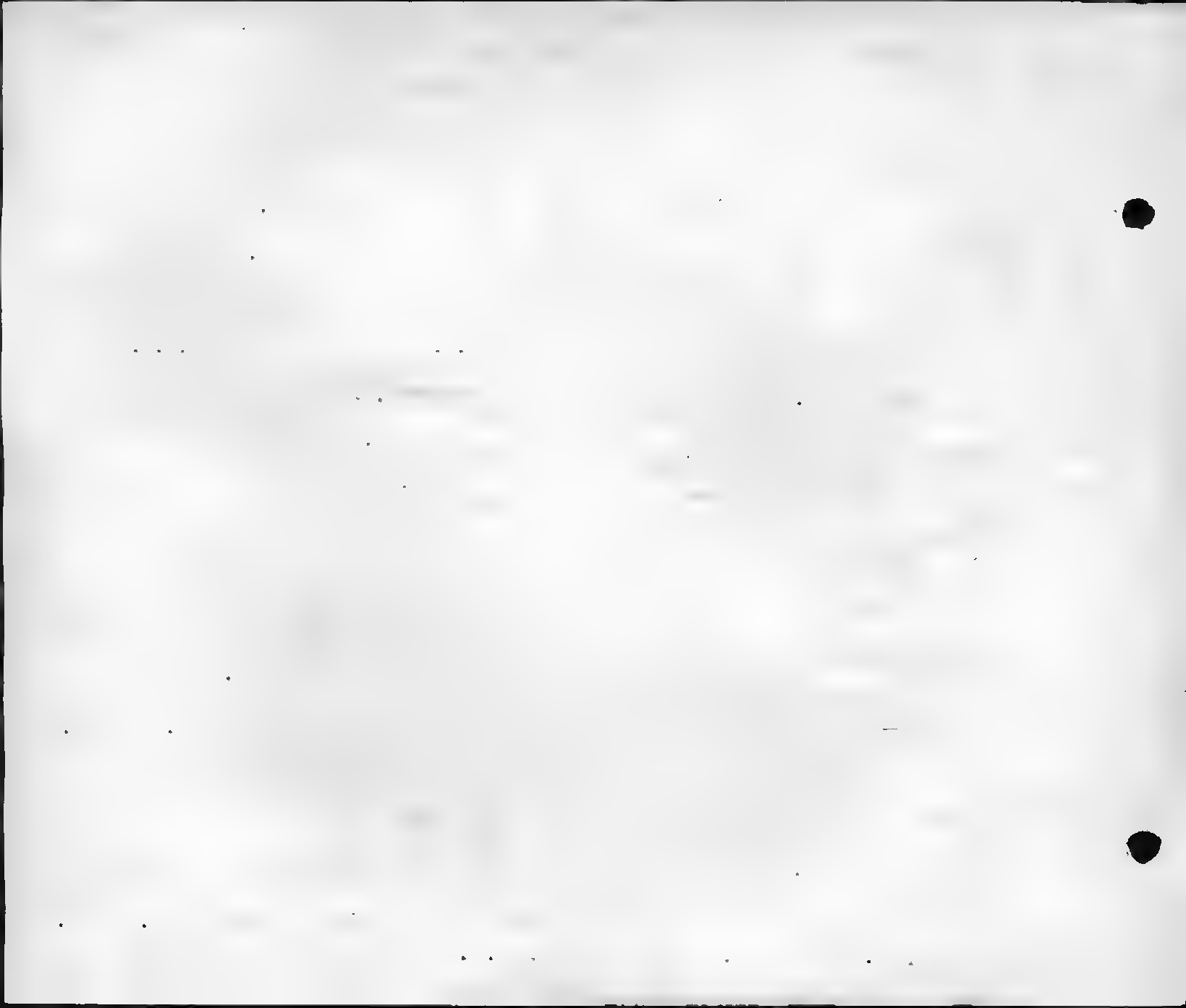
11525

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY in 1b <u>4 hrs.</u>		d. STREET ADDRESS <u>8511 West Howell Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Helen</u> First <u>B</u> Middle <u>Deoudes</u> Last		4 DATE OF DEATH Month <u>Oct.</u> Day <u>22</u> Year <u>19 60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>11/4/26</u>
9 AGE (In years last birthday) <u>33</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <u>D.C.</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Angelos H. Bacas</u>	
14. MOTHER'S MAIDEN NAME <u>Doula A. Metrakos</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO <u>3</u>		17. INFORMANT Address <u>Hospital record.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Herniation of brain stem</u> <u>825X</u> DUE TO (b) <u>Irreversible shock</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Massive hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of humerus - Crushed chest -</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Was passenger in car involved in auto accident.</u>	
20c. TIME OF INJURY Month, Day, Year <u>9:50</u> <u>9</u> <u>10</u> <u>22</u> <u>19 60</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>		20f. (City or town) <u>Bethesda</u> (County) <u>Montg.</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Brochart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Brochart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/25/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) <u>Prince Georges Co.</u> (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co.</u>		24a. REC'D BY REGISTRAR <u>OCT 25 '60</u>	
ADDRESS <u>Washington, D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Kras</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute, and certify, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be required by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11589

11526

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 6 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY St. Mary's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park d. STREET ADDRESS 93 Anderson Court e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Shawn Middle Michael Last DIVINE			4. DATE OF DEATH Month October Day 6 Year 19 60				
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-29-60		9. AGE (in years last birthday) 7 yrs		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Maryland St. Mary's Co.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Robert John DIVINE			14. MOTHER'S MAIDEN NAME Diana Jeanne BEARD				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (F) Robt. J. Divine, same as #2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 759.3 DUE TO Congenital Malformation, urinary system, bilateral hydronephrosis							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congenital malformation possibly of lung and possibly heart							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)							
21. I certify that (I) (physician) attended the deceased from Sept. 30 1960 to Oct. 6 1960 , that (I) xx lost saw the deceased alive on Oct. 6 1960 , and that death occurred at 12:05 PM M, from the causes and on the date stated above							
22a. SIGNATURE Lawrence G. Thorne M.D.		22b. DATE SIGNED 10-7-60					
22c. PHYSICIAN'S NAME (Type) Lawrence G. THORNE, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment		23b. DATE THEREOF 10-7-60		23c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cemetery			
23d. LOCATION (City, town, or county) Columbus		23e. (State) Ohio					
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey		24a. ADDRESS R. A. Pumphrey Funeral Home, Bethesda, Md.		25a. REC'D BY REGISTRAR Oct 10 '60			
25b. REGISTRAR'S SIGNATURE Arthur L. Kline							

20-1-1-1-1



CERTIFICATE OF DEATH

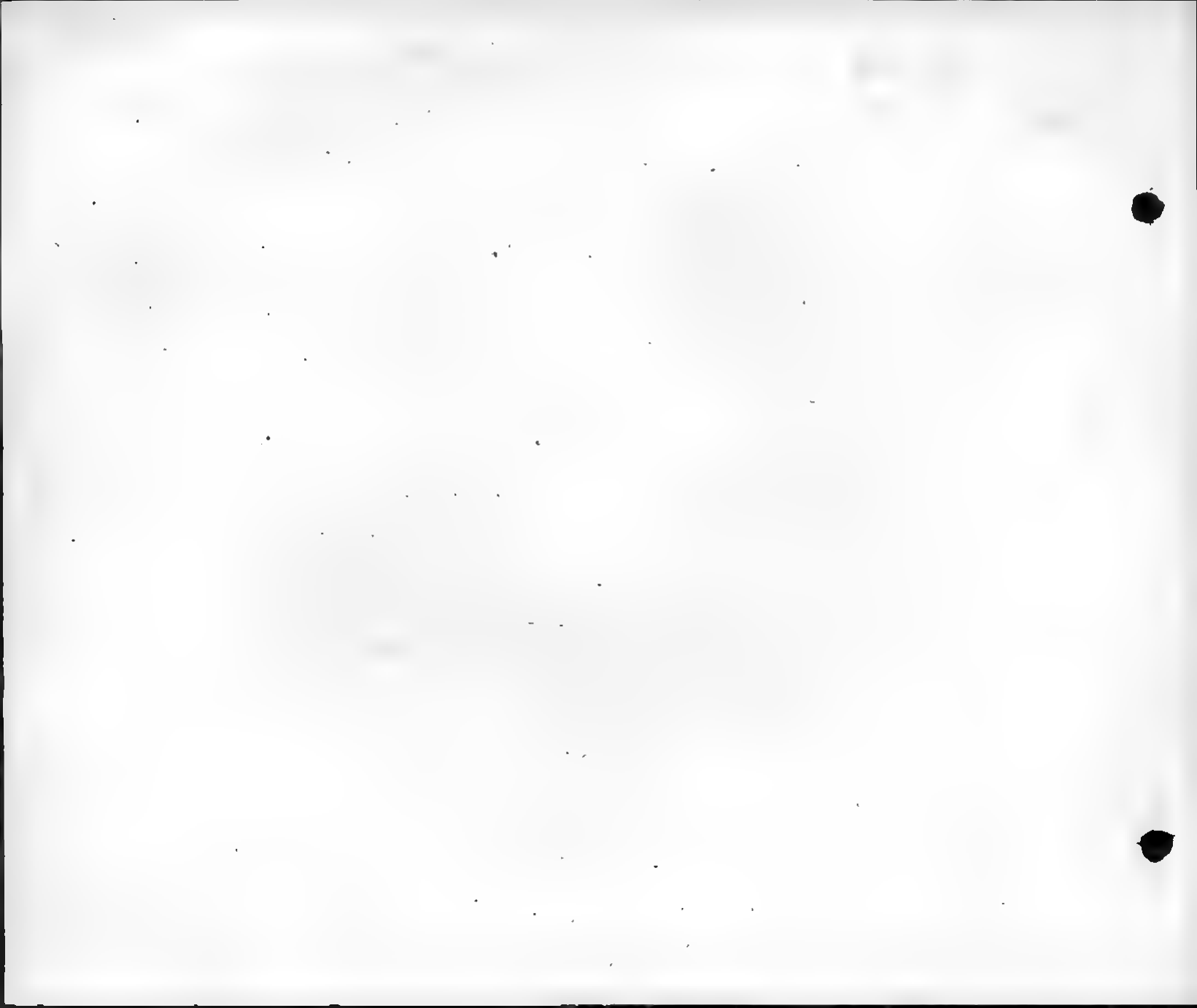
11527

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) German Town, Maryland		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle DANIEL Last DORSEY		4. DATE OF DEATH Month OCTOBER Day 17 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-20-1893
9. AGE (In years last birthday) 67 yrs.		10. F UNDER 1 YEAR IF UNDER 24 HRS Months 3 Days 21 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Gen'l. Farming	
11. BIRTHPLACE (State or foreign country) German Town, Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Bradley Dorsey		14. MOTHER'S MAIDEN NAME Ella Mae Slagle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Margaret F. Dorsey - German Town, Md	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremic poisoning DUE TO Metastatic Carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Colorectal carcinoma of prostate DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 1 month 16 months 16 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January, 1950 to Oct 16, 1960 , that I last saw the deceased alive on Oct 16, 1960 , and that death occurred at 3:20 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John G. Fawcett, M.D.		ADDRESS (Street, city or town, state) Dawsonville, Md DATE SIGNED 10-17-60	
PHYSICIAN'S NAME (Type) John G. Fawcett, M.D.		Dawsonville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-19-60	22c. NAME OF CEMETERY OR CREMATORY Neelsville Cemetery	22d. LOCATION (City, town, or county) (State) Mont. County, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Edith Martin		24a. REC'D BY REGISTRAR 316 E. Diamond Ave., Gaithersburg, Md. DATE OCT 19 1960	
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be required by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner's papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

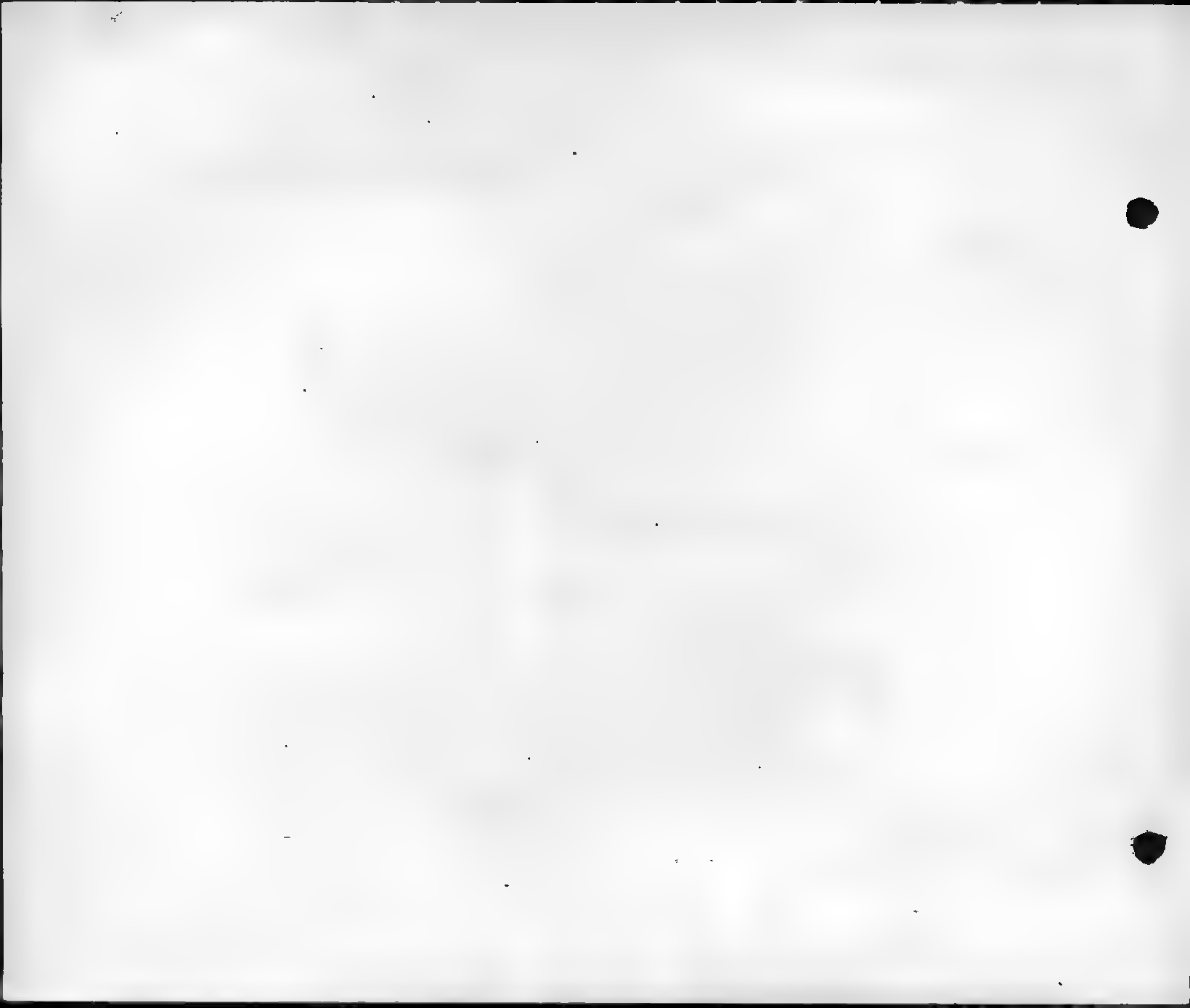
11527

11528

CERTIFICATE OF DEATH

Item 1 11527/5 10-18-60 et

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md</u> c. LENGTH OF STAY IN TB <u>one year</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. State</u>		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md</u> d. STREET ADDRESS <u>11119 Coleville Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>DAVID</u> Middle <u>H.</u> Last <u>DOSIK</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>11</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Wht</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-25-06</u>
9. AGE (In years last birthday) <u>54</u> yrs		IF UNDER 1 YEAR Months <u>5</u> Days <u>11</u> Hours <u>11</u> Min <u>11</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel Dosik</u>		14. MOTHER'S AIDEN NAME <u>ANNA Bloom</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Hosp Records</u>	
17. INFORMANT Address <u>Hosp Records</u>			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial Infarction.</u> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 1960</u> to <u>Oct 1960</u> that (I) (we) last saw the deceased alive on <u>10-11</u> 19 <u>60</u> , and that death occurred on <u>10-11</u> 19 <u>60</u> from the causes and on the date stated above			
22a. SIGNATURE <u>Robert Kramer</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT KRAMER, M.D.</u>		22d. ADDRESS <u>1703 East-West Highway.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10-12-60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>KING DAVID MEMORIAL GARDEN - FALLS CHURCH. VA.</u>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>B. Dancansky</u> ADDRESS <u>3501-14 St. N. W.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 13 '60</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



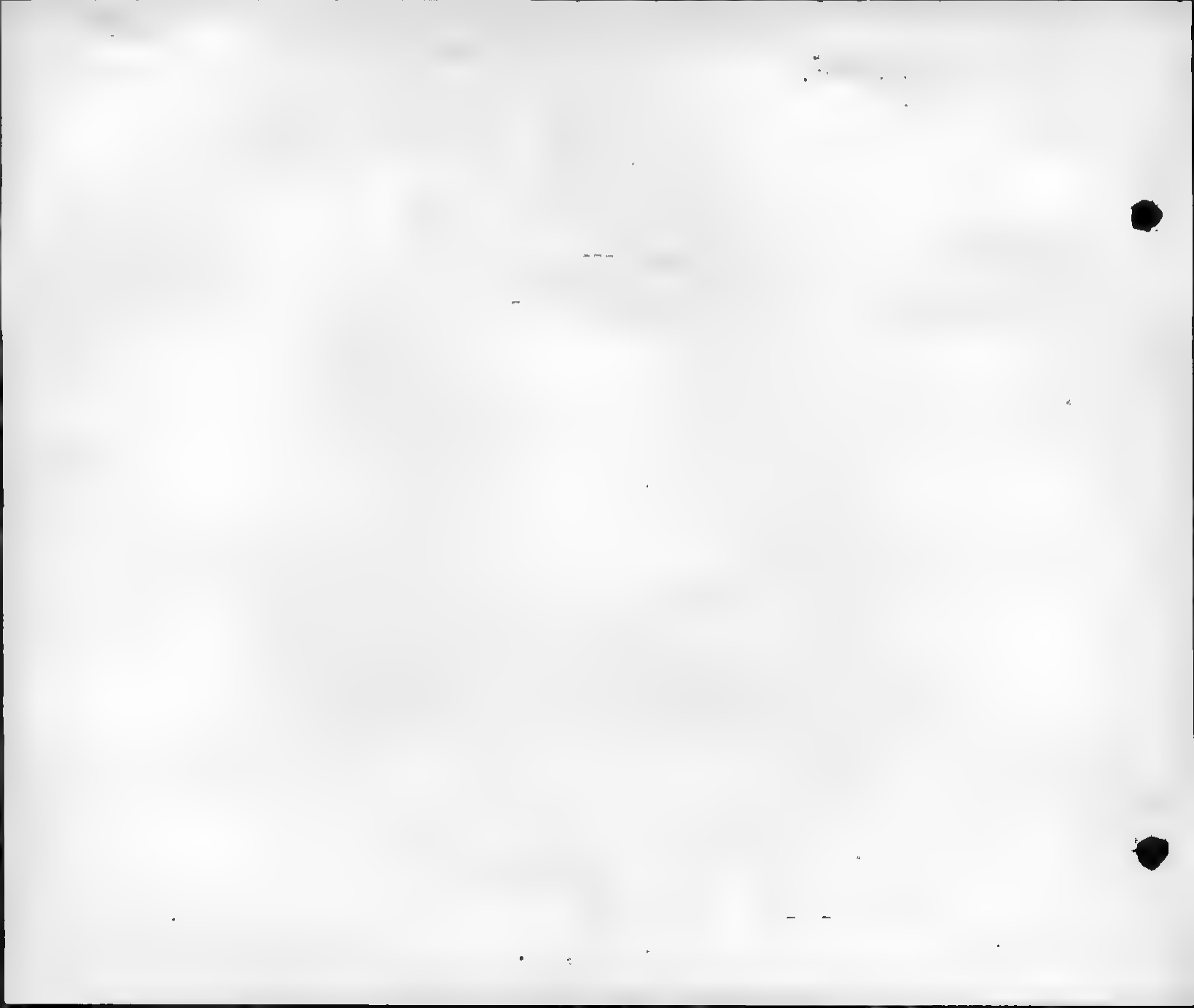
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11529

11591

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MARYLAND b COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY			c. LENGTH OF STAY IN 1b 1 HR. 15 MIN.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON GROVE		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL				d. STREET ADDRESS OAKMONT STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ARA Middle Roper Last DOVE				4. DATE OF DEATH Month OCTOBER Day 26 Year 19 60			
5 SEX FEMALE	6 COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH 8-8-1890		9 AGE (In years last birthday) yrs 70	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME WASHINGTON ALBERT ROPER				14. MOTHER'S MAIDEN NAME MARY CATHERINE HEDGES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17 INFORMANT HOSPITAL RECORDS, OLNEY, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) Heart Failure. DUE TO C.V.A. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Hypertension DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 4 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from OCT 17 to OCT 26 , 19 60 that (I) (we) last saw the deceased alive on OCT 26 , 19 60 , and that death occurred at 4:15 AM from the causes and on the date stated above.							
22a SIGNATURE <i>Francis H. Leal</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c PHYSICIAN'S NAME (Type) L. I. LEAL, M. D.				22d. ADDRESS GAITHERSBURG, MARYLAND			
23a BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 10-29-60		23c NAME OF CEMETERY OR CREMATORY Forest Oak		23d LOCATION (City, town, or county) (State) Gaithersburg, Md.	
24 FUNERAL DIRECTOR'S SIGNATURE <i>Francis H. Leal</i>				25a. REC'D BY REGISTRAR DATE OCT 31 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kneiss</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be re- by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

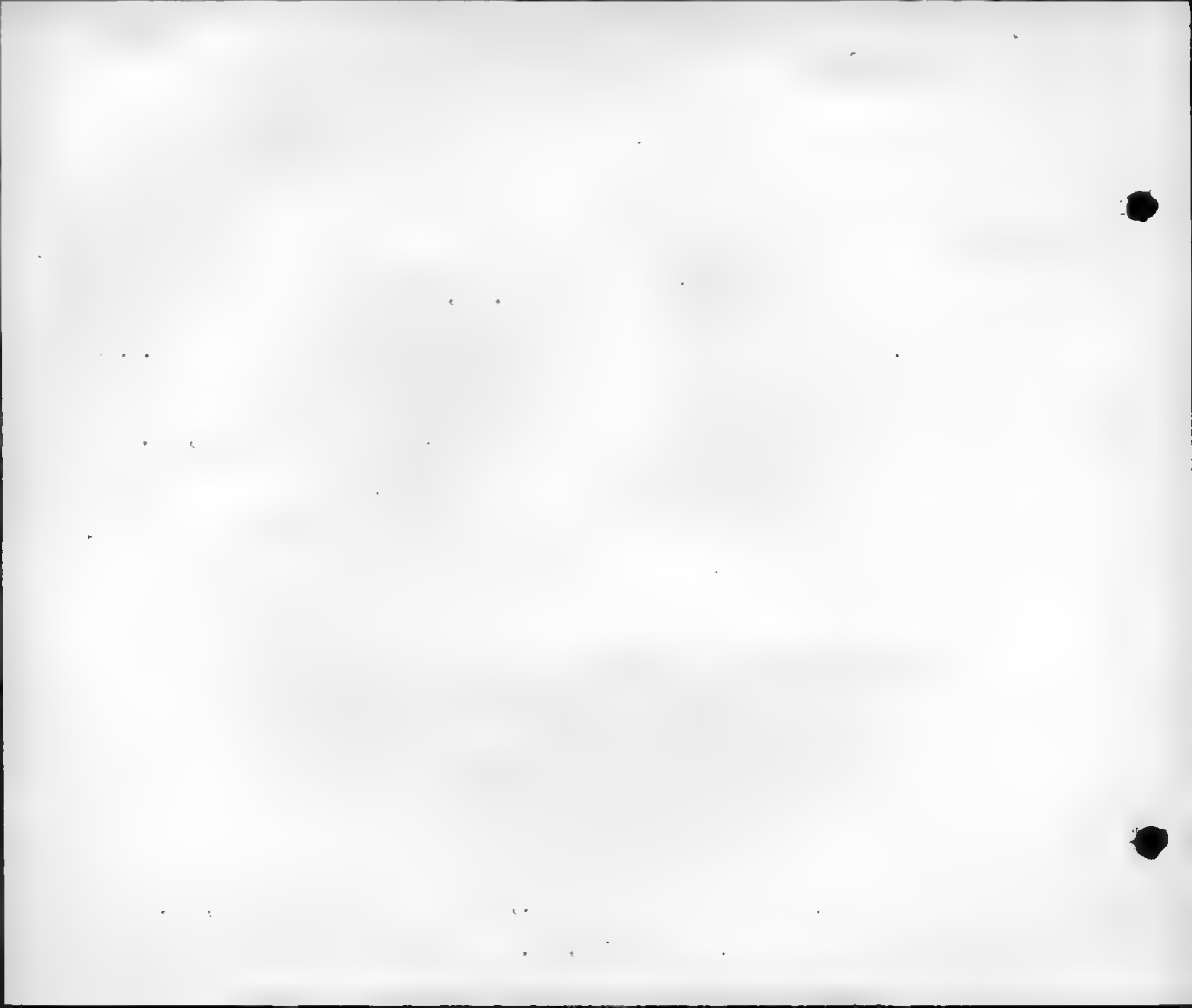
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11592

11530

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg (Rural)</u>			c. LENGTH OF STAY IN 1b <u>20 yrs</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg (Rural)</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Emory Grove Rd</u>				d. STREET ADDRESS <u>Emory Grove Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>LOUISE</u> Last <u>DYSON</u>				4. DATE OF DEATH Month <u>October</u> Day <u>2</u> Year <u>19 60</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 28, 1898</u>		
9. AGE (In years last birthday) <u>62</u> yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Zackariah Hawkins</u>				14. MOTHER'S MAIDEN NAME <u>Suzenna Stewart</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Howard Dyson Gaithersburg, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Heart Failure</u> <u>722.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Rheumatoid Arthritis</u> DUE TO (c) <u>Myocarditis, Chronic.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>about 15 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1957</u> , 19 <u>57</u> , to <u>Oct 2</u> , 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Oct 1</u> , 19 <u>60</u> , and that death occurred on <u>Oct 2</u> , 19 <u>60</u> , from the causes and on the date stated above.								
22a. SIGNATURE <u>Luciano I. Leal</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <u>Luciano I. Leal</u>				22d. ADDRESS <u>Gaithersburg Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/6/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Brooke Grove.,</u>		23d. LOCATION (City, town, or county) (State) <u>Laytonsville, Md.</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Swode</u>				ADDRESS <u>Rockville, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 7 '60</u>		
				25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kane</u>				

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

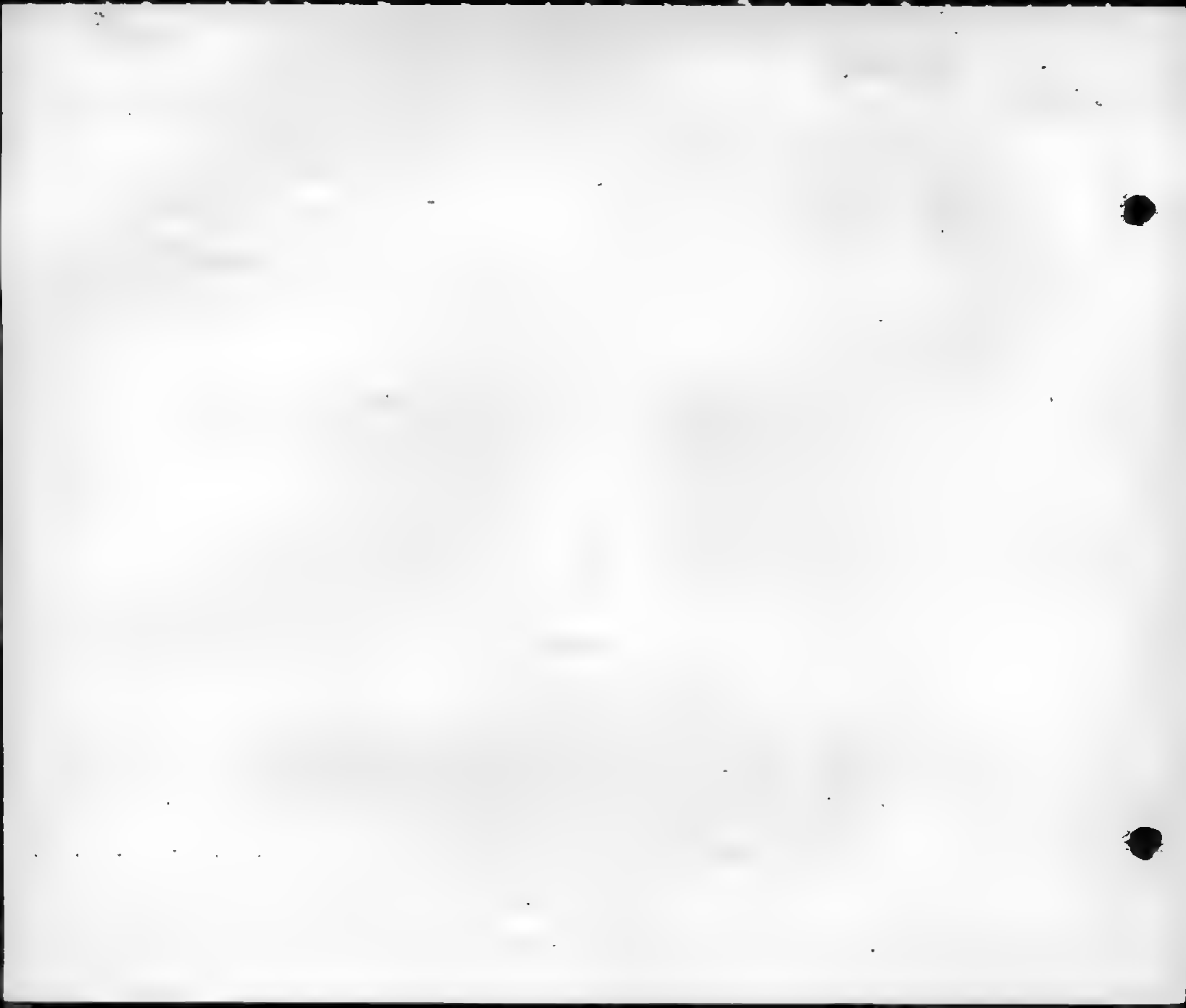
VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11593

11531

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 1 month		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Resmor Sanitarium & Hospital			d. STREET ADDRESS 3505 Thormapple Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First JOHN Middle BUCKINGHAM Last ENGLISH			4. DATE OF DEATH Month Oct Day 16 Year 1960		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/1/1878		9. AGE (In years last birthday) 81 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Builder-retired		10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Delaware	
13. FATHER'S NAME Thom as English			12. CITIZEN OF WHAT COUNTRY? US		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO Yes		17. INFORMANT Carl M English-son-same 2d
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 422-2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Coronary Heart Failure DUE TO (c) Myocarditis					INTERVAL BETWEEN ONSET AND DEATH 3 d.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 5000 Reno Road, N. W., Wash. D. C.	
20f. (City or town) Rockville, Maryland		(County) Montgomery		(State) Maryland	
21. I certify that (I) (this hospital) attended the deceased from Sept. 1958 to Oct 16, 1960 , that (I) (we) last saw the deceased alive on 10-15-1960 , and that death occurred at 6 A.M. from the causes and on the date stated above.					
22a. SIGNATURE William Fleet Luckett			22b. DATE SIGNED 10-16-60		
22c. PHYSICIAN'S NAME (Type) William Fleet Luckett			22d. ADDRESS 5000 Reno Road, N. W., Wash. D. C.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/19/60		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery	
23d. LOCATION (City, town, or county) Rockville, Maryland		(State) Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey			ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE OCT 18 '60
25b. REGISTRAR'S SIGNATURE Arthur S. Kline					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11532

11528

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>D.C.</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>N.W. Washington, D.C.</u> 47X-	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>75 Washington San. & Hospital</u>		d. STREET ADDRESS <u>700 Madison Street, Apt. 201</u>	
3. NAME OF DECEASED (Type or print) First <u>(Infant)</u> Middle <u></u> Last <u>Errigo</u>		4. DATE OF DEATH Month <u>10</u> Day <u>18</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-17-60</u>
9. AGE (In years last birthday) yrs. <u>13</u> Min. <u>42</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u></u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Paolo (NMN) Errigo</u>		14. MOTHER'S MAIDEN NAME <u>Grace (NMN) Errigo</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Anoxia</u> <u>761.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>remained separate of placenta</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>19</u> to <u>19</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Winston E. Cochran</u> M.D. <u>927 Pershing Dr., Silver Spring, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Winston E. Cochran, M. D.</u> <u>927 Pershing Dr., Silver Spring, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>9-19-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium & Hospital, Takoma Park, Maryland</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Hare, M. D. Washington Sanitarium and Hospital</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Hare</u> 24b. REGISTRAR'S SIGNATURE	

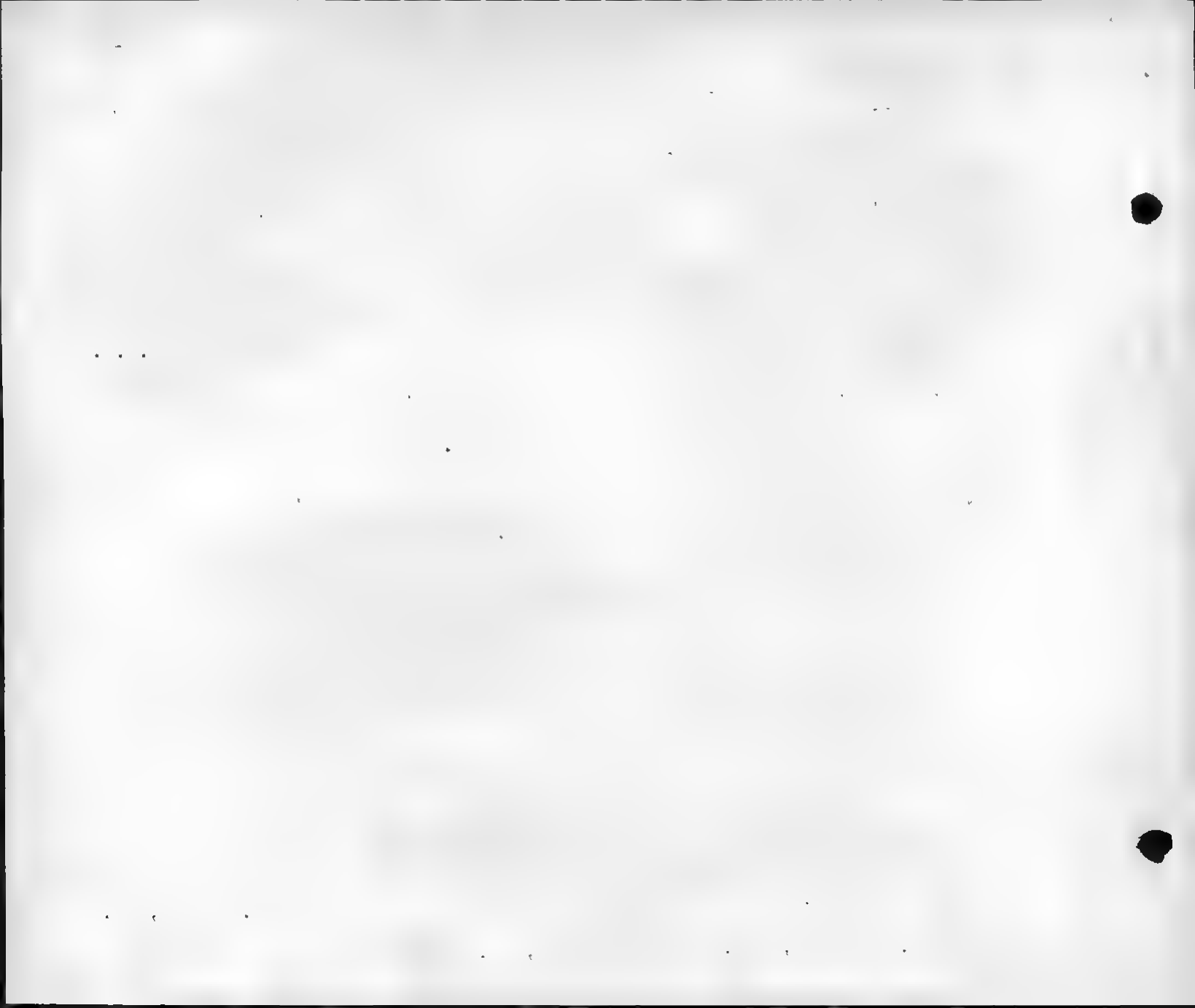


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
4
11594
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11533

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 30 minutes	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. STREET ADDRESS 100 Primrose St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Hattie Middle Irene Last Essex		4. DATE OF DEATH Month 10/ Day 6 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/22/82
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min 78	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Christopher Columbus Murphy		14. MOTHER'S MAIDEN NAME CATHERINE Washington Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Evelyn E. Mills		Address same as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction 4-2-0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 4-12-60	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 6, 1960 , to Oct 6, 1960 , that (I) (we) last saw the deceased alive on Oct 6, 1960 , and that death occurred at 12:40 PM , from the causes and on the date stated above.			
22a. SIGNATURE George J. Harper		22b. DATE SIGNED Oct 6 1960	
22c. PHYSICIAN'S NAME (Type) George J. Harper		22d. ADDRESS 10511 W. 4th St. + 1/2 N. Kensington, Md.	
23a. BURIAL CREMATION REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/10/60	
23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		23d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC.		25a. REC'D BY REGISTRAR OCT 11 '60	
ADDRESS SILVER SPRING, MD.		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11534

11595

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY			c. LENGTH OF STAY IN 1b 13 DAYS			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GAITHERSBURG	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL				d. STREET ADDRESS #2 LAYTONSVILLE PIKE			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First DUANE Middle LEE Last FINK				4. DATE OF DEATH Month OCTOBER Day 19 Year 19 60			
5 SEX MALE	6. COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH OCTOBER 6, 1960		9 AGE (In years last birthday) yrs. 13	IF UNDER 1 YEAR Months 13 Days 13	IF UNDER 24 HRS Hours 13 Min 13
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Olney, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME RAYMOND AUSTIN FINK				14. MOTHER'S MAIDEN NAME MARGRETTA BARBER SMITH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT HOSPITAL RECORDS, OLNEY, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 783.5 Bilateral Bronchopneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prematurity and Immaturity (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from 10-6-1960 to 10-19-1960 , that (I) (we) last saw the deceased alive on 10-19-1960 , and that death occurred at 12:05 PM , from the causes and on the date stated above.							
22a. SIGNATURE <i>A. D. Bonifant</i>				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) A. D. BONIFANT, M. D.				22d. ADDRESS SANDY SPRING, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-19-60		23c. NAME OF CEMETERY OR CREMATORY St. Luke		23d. LOCATION (City, town, or county) _____ (State) _____ Redland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Francis K. Barber</i>				ADDRESS Laytonsville, Md.		25a. REC'D BY REGISTRAR DATE NOV 2 '60	
				25b. REGISTRAR'S SIGNATURE <i>Arthur S. House</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

2173 36 4 XV 0



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

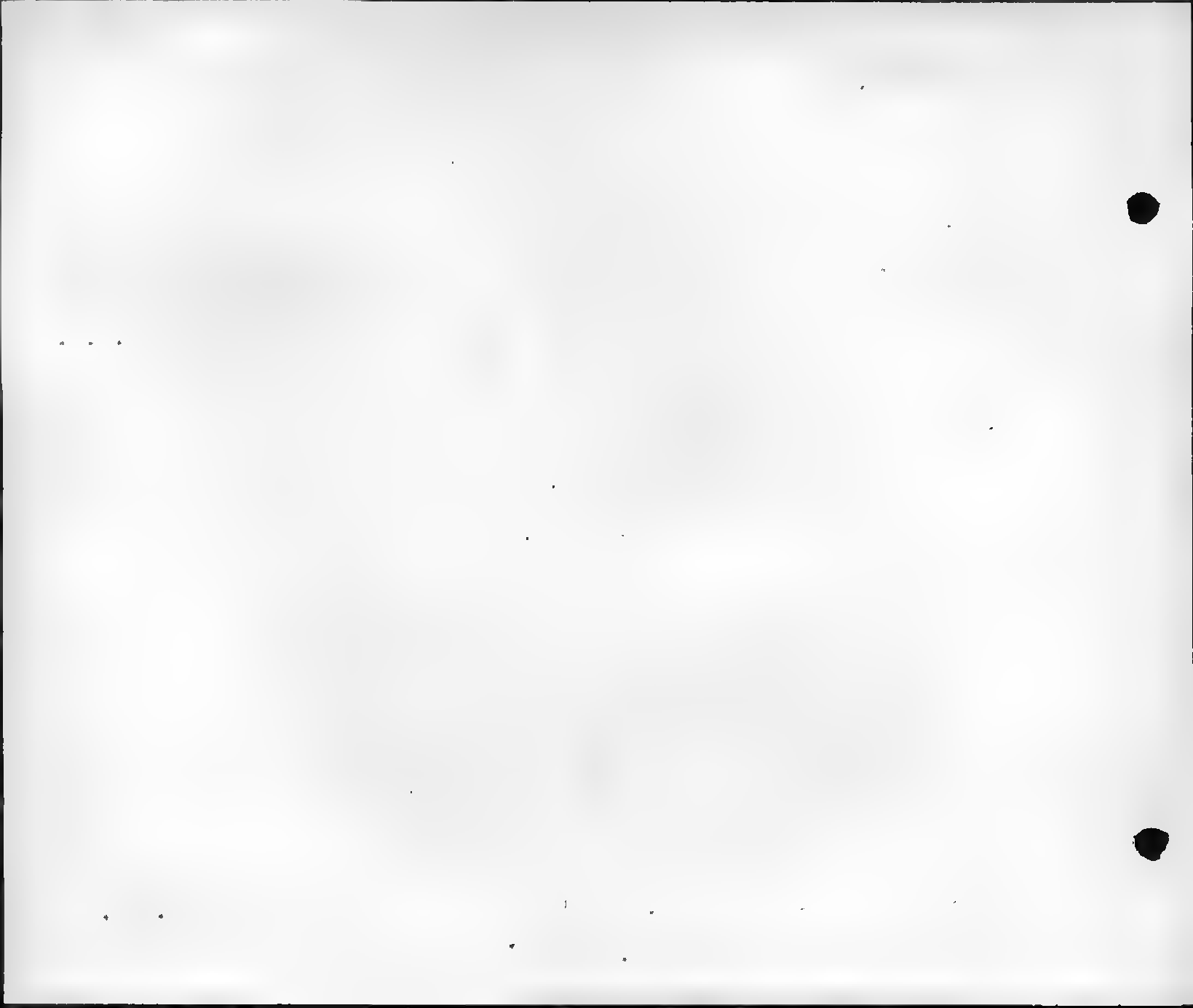
VR A154
15M 9/60

1
11596
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11535

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 9 HOURS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GAITHERSBURG	
		d. STREET ADDRESS R-2	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DWIGHT Middle LEE Last FINK		4. DATE OF DEATH Month OCTOBER Day 6, Year 19 60	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 6, 1960
9. AGE (In years last birthday) yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME RAYMOND AUSTION FINK		14. MOTHER'S MAIDEN NAME MARGRETTA BARBER SMITH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT MOTHER - HOSPITAL RECORDS, OLNEY, MARYLAND		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelectasis bilateral 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity (6months gestation) DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from 10/6 19 60 to 10/6 19 60 , that (1) (we) last saw the deceased alive on 10/6 19 60 , and that death occurred at 10 PM , from the causes and on the date stated above.			
22a. SIGNATURE A. D. Bonifant		22b. DATE SIGNED 10-7-60	
22c. PHYSICIAN'S NAME (Type) A. D. BONIFANT, M. D.		22d. ADDRESS SANDY SPRING, MARYLAND	
23a. BURIAL, CREMATION, or other disposal (Specify) Burial		23b. DATE THEREOF 10-7-60	
23c. NAME OF CEMETERY OR CREMATORY St. Luke's		23d. LOCATION (City, town, or county) (State) Redland Mont. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber		25a. REC'D BY REGISTRAR Francis H. Barber	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		DATE OCT 11 '60	

2273365XVJ



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the following is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11597

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11536

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>London</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lincoln</u> (rural)	
c. LENGTH OF STAY IN TB <u>10 days</u>		d. STREET ADDRESS <u>None</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>13005 Parkland Dr</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ambrey</u>		4. DATE OF DEATH <u>Oct 17 1960</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>5-3-1886</u>		9. AGE (In years if UNDER 1 YEAR if UNDER 24 HRS. last birthday) <u>74</u> yrs Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Famer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Va. (Fauquier Co.)</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Flynn</u>		14. MOTHER'S MAIDEN NAME <u>Julia Flynn Ball</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or defense service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Anna Laurie Flynn (wife)</u>		Address <u>Item 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-20-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Lincoln, Virginia</u>	
23. FUNERAL DIRECTOR <u>Hall Funeral Home - Purcellville, Va.</u>		24. REC'D BY REGISTRAR <u>Alice C. Hall</u>	
24b. REGISTRAR'S SIGNATURE <u>Alice C. Hall</u>		DATE <u>OCT 19 '60</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11598

11537

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN lb 111 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Johnstown		
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 731 Smith Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Thomas Middle (None) Last Fogel				4. DATE OF DEATH Month October Day 2 Year 1960			
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 14, 1951		9. AGE (In years last birthday) 9 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward J. Fogel				14. MOTHER'S MAIDEN NAME Ann Karlik			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute lymphatic leukemia 204-5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH 18 months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (it) (this hospital) attended the deceased from June 13, 1960 to October 2, 1960 , that (it) (we) last saw the deceased alive on October 2, 1960 , and that death occurred at 8:30 AM from the causes and on the date stated above.							
22a. SIGNATURE Jerome B. Block, M.D.				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 10/2/60		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Jerome B. Block, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-5-1960		23c. NAME OF CEMETERY OR CREMATORY ST PETER + PAUL CEM		23d. LOCATION (City, town, or county) (State) JOHNSTOWN CAMBRIA COUNTY, PA.	
24. FUNERAL DIRECTOR'S SIGNATURE W. L. Lindquist Co., 1401 Grafton St.				25a. REC'D BY REGISTRAR DATE OCT 6 '60		25b. REGISTRAR'S SIGNATURE Charles S. Kenna	



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11599

11538

Item 21 Film 6275 10-21-60 at

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 36 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY District of Columbia c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 2431 Newton Street, N.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First Ennis Middle Lee Last Ford		4. DATE OF DEATH Month October Day 14 Year 1960		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 23, 1889		9. AGE (In years last birthday) 71		10. IF UNDER 1 YEAR Months 1 Days 14 Hours 19 Min. 60			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Apartment House Mgr.				10b. KIND OF BUSINESS OR INDUSTRY Apartment House				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME John Ford						14. MOTHER'S MAIDEN NAME Indiana Ford											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No						16. SOCIAL SECURITY NO. 216-09741851						17. INFORMANT The Medical Record Address Unascertainable The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: 204.3 IMMEDIATE CAUSE (a) Acute Myelogenous Leukemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO INTERVAL BETWEEN ONSET AND DEATH months																	
PART II OTHER SIGNIF. CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)													
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from Sept. 8, 1960 to October 14, 1960 , that (I) (we) last saw the deceased alive on October 14, 1960 , and that death occurred on Oct. 14, 1960 at 4:15 a.m. from the causes and on the date stated above.																	
22a. SIGNATURE Edward E. Morse				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED 10/14/60									
22c. PHYSICIAN'S NAME (Type) Edward E. Morse, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.													
23a. BURIAL, CREMATION REMOVAL (Specify) Burial				23b. DATE THEREOF 10/17/60				23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial				23d. LOCATION (City, town or county) (State) Baltimore 14, Maryland					
24. FUNERAL DIRECTOR'S SIGNATURE L. Scott Brooks				ADDRESS 622 York Road Towson, Md.				25a. REC'D BY REGISTRAR DATE OCT 19 '60				25b. REGISTRAR'S SIGNATURE Arthur L. Kraus					

MEDICAL CERTIFICATION

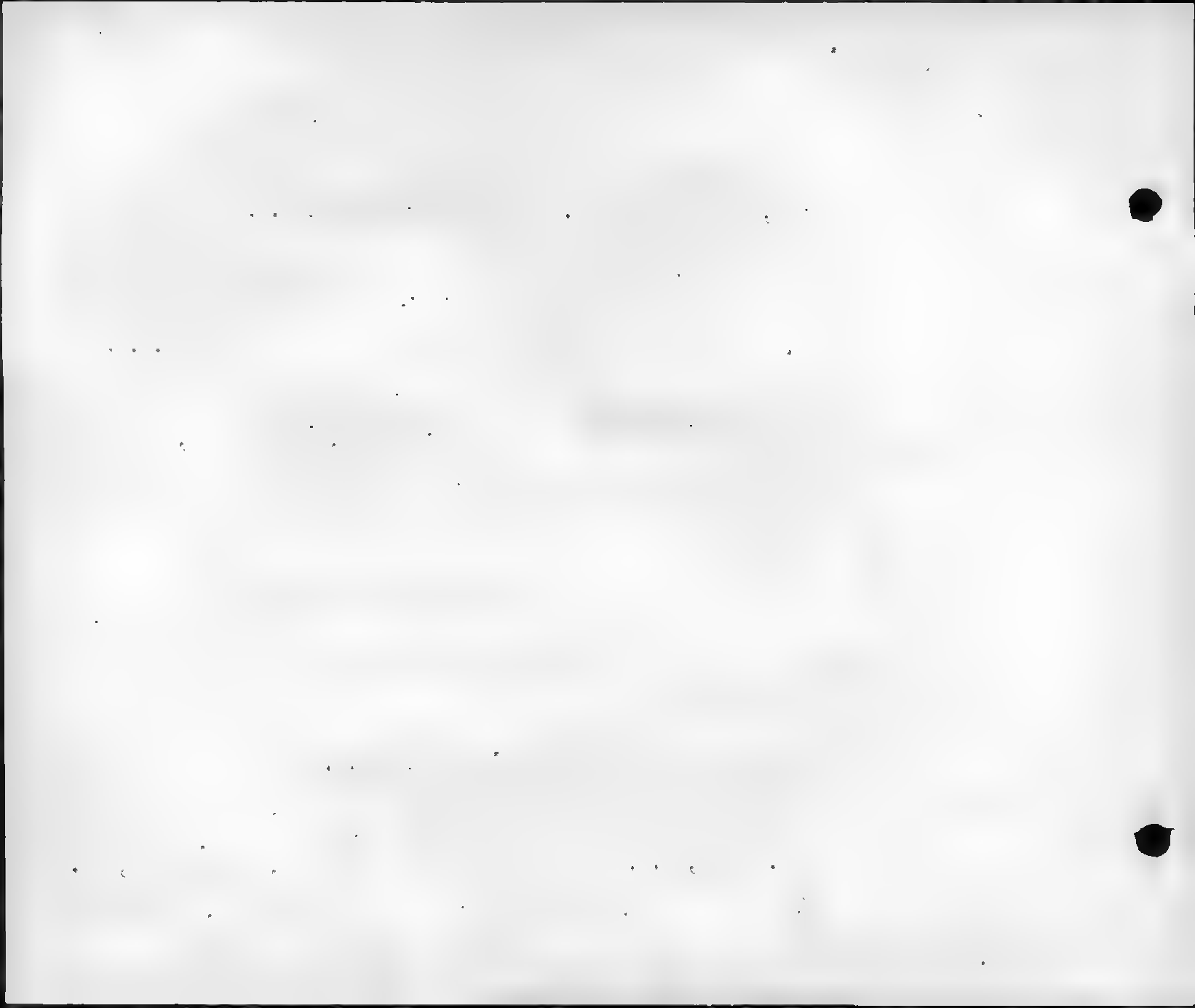
89

1

050

M

1044 1 2



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11539

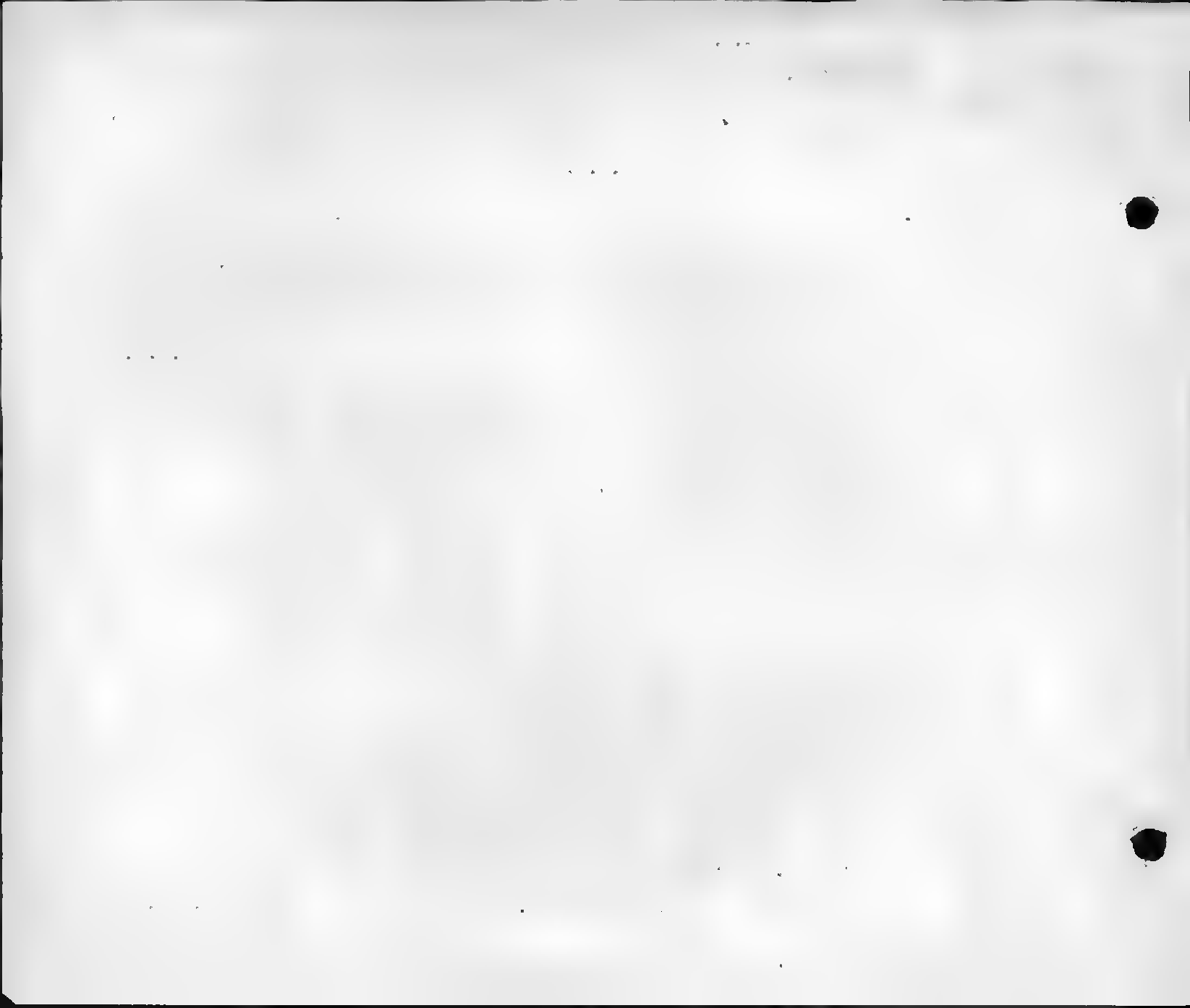
Reg. Dist. No.

11600

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. STREET ADDRESS <u>Goshen Rd. R - 1</u>	
3. NAME OF DECEASED (Type or print) <u>Harriet Franklin</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>25</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/17/1900</u>
9. AGE (in years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR Months <u></u> Days <u></u>	
11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
13. FATHER'S NAME <u>Charles Stewart</u>		14. MOTHER'S MAIDEN NAME <u>Annie Wilson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO <u></u>	
17. INFORMANT <u>Ermatian Furlow</u>		Address <u>Item 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u></u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a. m. <u></u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Brochart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Brochart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 10/25/60	
22a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/29/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Brooke Grove.</u>		22d. LOCATION (City, town, or county) (State) <u>Laytonsville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u> ADDRESS <u>Rockville</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 31 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>William S. Frank</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

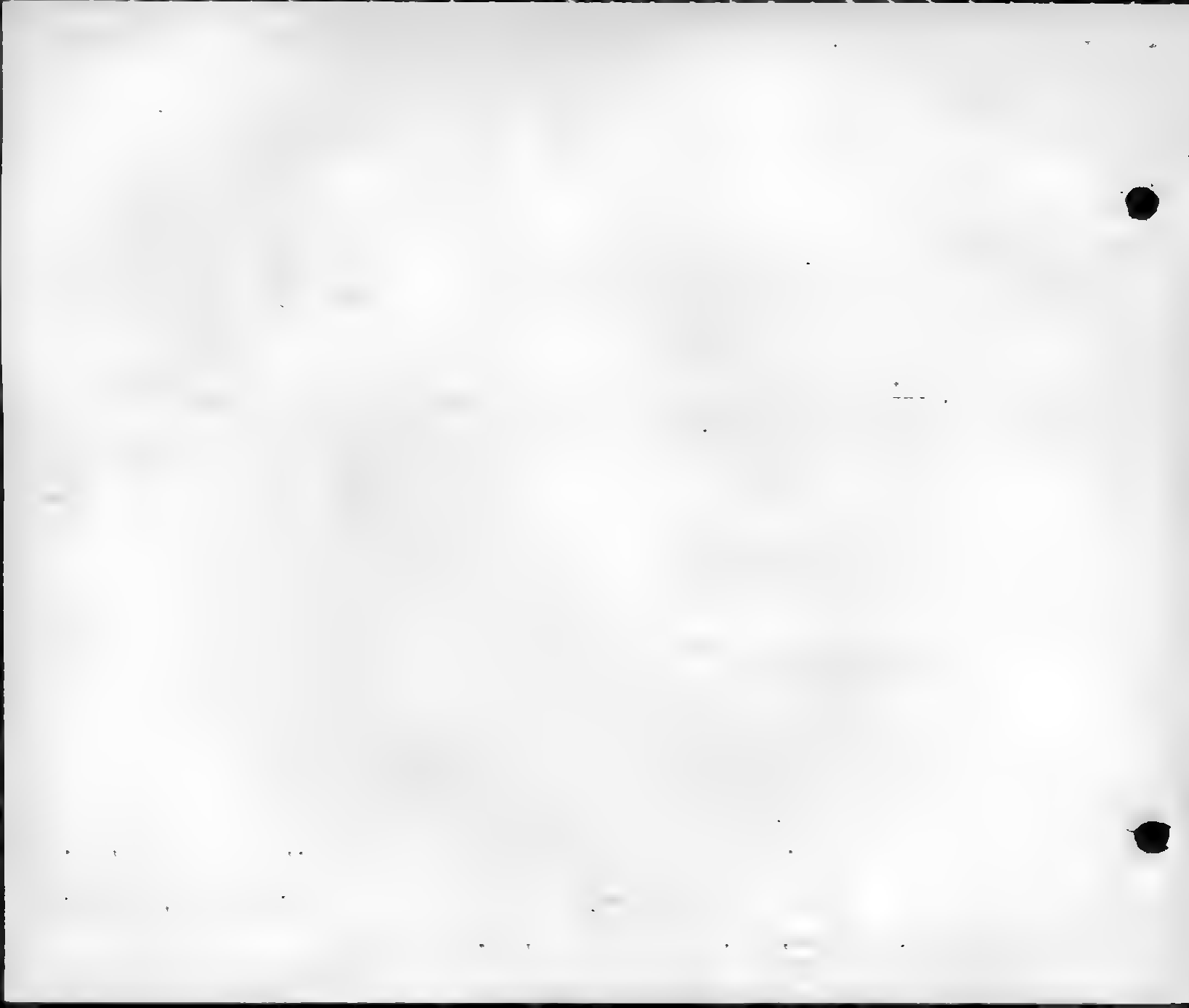
11529

11540

1

UNITED STATES DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
c. LENGTH OF STAY IN 1b <u>10 1/2 hours</u>				d. STREET ADDRESS <u>1507 East West Highway</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium and Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last <u>Martha</u> <u>Lena</u> <u>Gainey</u>				4. DATE OF DEATH Month Day Year <u>October</u> <u>24</u> <u>1960</u>			
5 SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>May 20, 1886</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11 BIRTHPLACE (State or foreign country) <u>Florida</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>John L. O'Berry</u>				14. MOTHER'S MAIDEN NAME <u>Mary Frances Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17 INFORMANT Address <u>Washington Sanitarium and Hospital Records</u>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a) <u>PONTINE HEMORRHAGE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>12 HRS</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>OCT. 23</u> <u>1960</u> , to <u>OCT. 24</u> <u>1960</u> , that (I) (we) last saw the deceased alive on <u>OCT. 24</u> <u>1960</u> , and that death occurred at <u>4:29</u> AM, from the causes and on the date stated above							
22a. SIGNATURE <u>James A. Roberts</u>				22b. DATE SIGNED <u>10/24/60</u>			
22c. PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS</u>				22d. ADDRESS <u>8907 Georgia Ave., Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10/27/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey, Inc.</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 28 '60</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur D. Frank</u>							



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11530

11541

Item 6 Film 62-11-2-60-47

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>47X</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, MD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, DC</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. Hospital</u>		d. STREET ADDRESS <u>423 Upshur St. N.W.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mr. Benjamin (mm) Haller</u>		4. DATE OF DEATH Month Day Year <u>10 25 1960</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-1-80</u>
9. AGE (In years last birthday) <u>80</u> yes		IF UNDER 1 YEAR Months Days Hours Min. <u>80</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Tailor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Russia</u>	
11 BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Leon Gallet</u>		14 MOTHER'S MAIDEN NAME <u>Anna Machelik</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Hospital Chart</u>	
17 INFORMANT <u>Hospital Chart</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal insufficiency</u> DUE TO (b) <u>Cerebral thrombosis</u> DUE TO (c) <u>Carcinoma of larynx</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>30 days</u> <u>8 mos</u>	
PART II. OTHER SIGNIF. CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Craniotomy and nerve root section for pain relief 9/26/60</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a m p. m. <u>19</u>		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>9/21, 1960</u> to <u>9/24, 1960</u> , that (I) (we) last saw the deceased alive on <u>9/24, 1960</u> and that death occurred at <u>11:45 A</u> PM, from the causes and on the date stated above.		22a. SIGNATURE <u>John T. Lord M.D.</u> M D	
22b. PHYSICIAN'S NAME (Type) <u>John T. Lord, M.D.</u>		22c. ADDRESS <u>1015 Spring St. Silver Sp. Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>ect-46-60</u>		23b. DATE THEREOF <u>10/25/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Chesnutgrad Ave</u>		23d. LOCATION (City, town, or county) (State) <u>Washington DC</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>B Danyausky</u> ADDRESS <u>4 hrs 3501-14th St NW</u>		25a. REC'D BY REGISTRAR <u>DOCT 28 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			



Dr. Brochart Notified

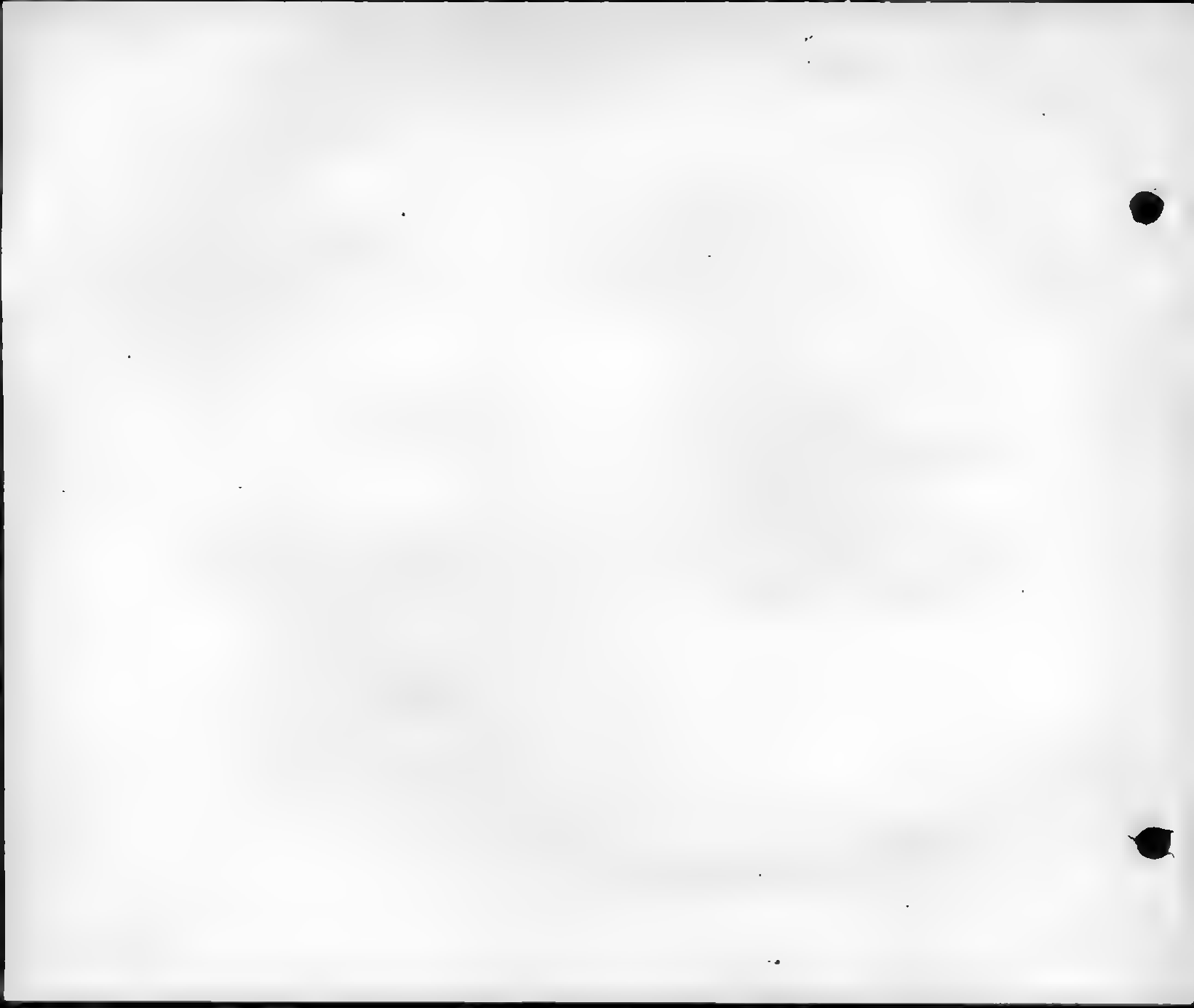
MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11601

11542

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>3721 Warren St. N. W.</u>	
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>HENRY</u> Last <u>GERNER</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>21</u> Year <u>1960</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/7/1891</u>
9 AGE (in years last birthday) <u>69</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	11. BIRTHPLACE (State or foreign country) <u>Vash. D. C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Charles E. Gerner</u>	
14. MOTHER'S MAIDEN NAME <u>Louise E. Ri ese</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>Army</u>	
16. SOCIAL SECURITY NO		17. INFORMANT <u>Brother Ernest Gerner</u> Address <u>Same as Above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> (c) <u>12 hours</u> years		INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>1950</u> to <u>present</u> , that (I) (we) last saw the deceased alive on <u>10-31-1960</u> , and that death occurred at <u>5:00 A.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>C.P. Ryland</u>		22b. DATE <u>10-31-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles P. Ryland</u>		22d. ADDRESS <u>4400-49 St NW Washington DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov 3 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Wash. DC</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Deal Funeral Home</u>		25a. REC'D BY REGISTRAR <u>4812 92. Ave NW</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>NOV 3 '60</u>	



CERTIFICATE OF DEATH

11543
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DC b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 30 days	
d. NAME OF HOSPITAL (If not in hospital give street address) WHEATON NURSING HOME		e. STREET ADDRESS 1701 SYCAMORE ST. NW.	
3. NAME OF DECEASED (Type or print) First Middle Last BESSIE — GINSBURG		4. DATE OF DEATH Month Day Year OCT. 4 - 1960	
5. SEX FEMALE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH ? 1880 80
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE -		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME MORRIS WHITMAN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MORRIS GINSBURG		Address 1701 SYCAMORE ST. NW. DC	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X Branchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH 1 wk.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 19 49 to Oct 4 1960 that I lost s/he the deceased alive on Oct 3 1960 , and that death occurred at 4:45 P. M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Lawrence J. Thomas M.D.		ADDRESS (Street, city or town, state) 900 17th St N.W. - WASH, DC.	
PHYSICIAN'S NAME (Type) LAWRENCE J. THOMAS		DATE SIGNED 9/4/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 10/5/60		22b. DATE THEREOF 10/5/60	
22c. NAME OF CEMETERY OR CREMATORY BETH SHOLOM TEM		22d. LOCATION (City, town, or county) (State) CAP. HTS., MD	
23. FUNERAL DIRECTOR'S SIGNATURE Gooding Funeral Home		ADDRESS 4217-9th NW	
24a. REC'D BY REGISTRAR OCT 7 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL: This certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the following is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11558 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11544

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>B+O R R near 1550 Rockville Pike</u>		d. STREET ADDRESS <u>11 1550 Atlantic Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>PAUL MICH EL GRANT</u>		4. DATE OF DEATH <u>October 19 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/25/40</u>
9. AGE (in years last birthday) <u>11</u> yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Paul F. Grant</u>		14. MOTHER'S MAIDEN NAME <u>Marguerite F. Bohn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Paul F. Grant-Itz</u>	
17. INFORMANT <u>Paul F. Grant-Itz</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage & laceration</u> DUE TO (b) <u>Compound fracture of skull</u> DUE TO (c) <u>Head partially decapitated</u>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Struck by train</u>	
20c. TIME OF INJURY Month, Day, Year <u>5:25 a.m. 10-25 1960</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>B+O R R</u>	20f. (City or town) (County) (State) <u>Rockville Montg md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/27/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or country) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		DATE <u>OCT 27 '60</u>	



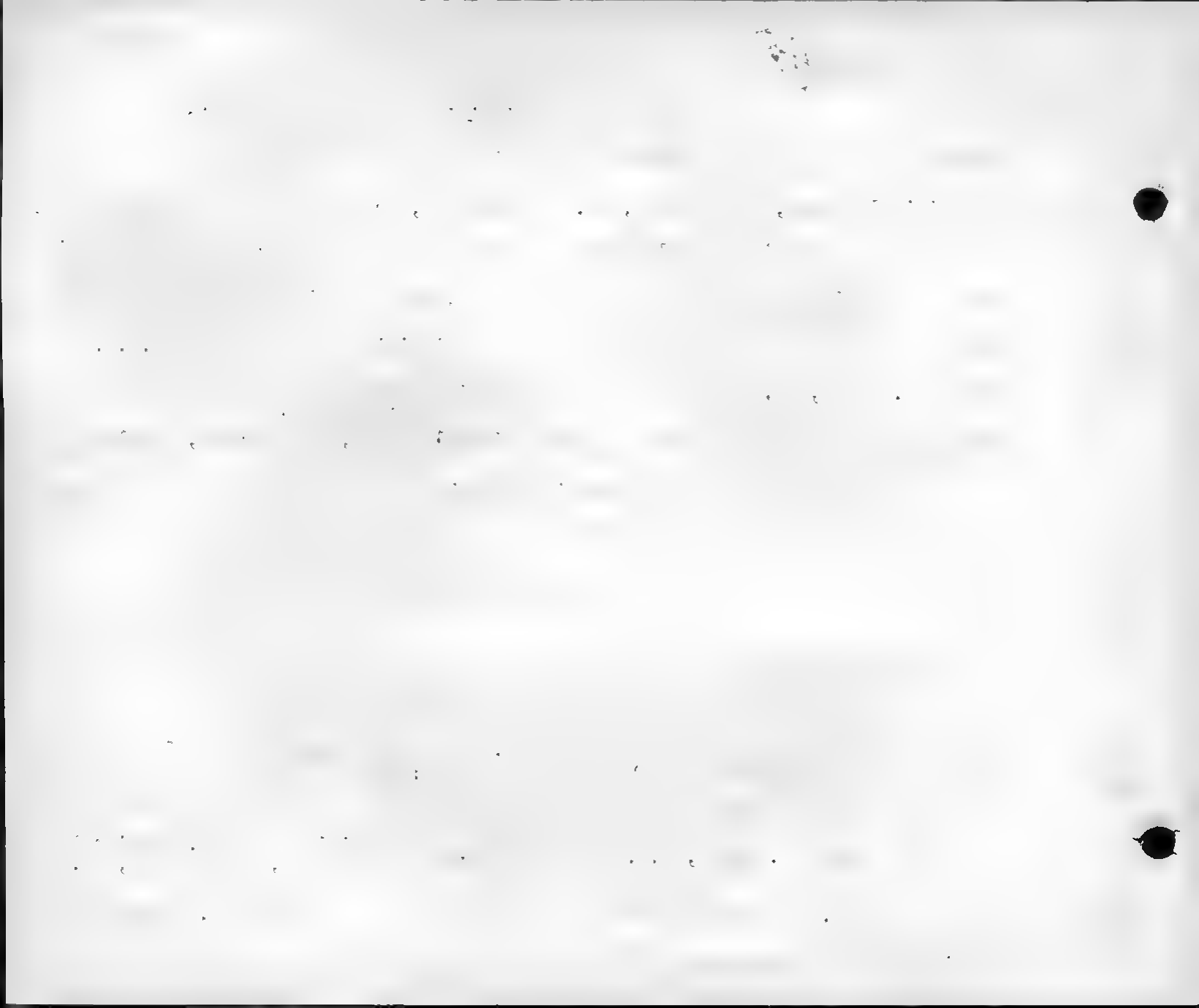
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11545

11602

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Virginia b. COUNTY Fairfax			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 11 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS Route # 5, Box 183			
3. NAME OF DECEASED (Type or print) First Bonnie Middle Elizabeth Last Green				4. DATE DEATH Month October Day 11 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 13, 1950		9. AGE (In years last birthday) 10 yrs	10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles W. Green, Jr.				14. MOTHER'S MAIDEN NAME Nellie Preston			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown, If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Lymphatic leukemia 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH 9 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 30, 1960 , to October 11, 1960 , that (I) (we) last saw the deceased alive on October 11, 1960 , and that death occurred at 7:15 AM from the causes and on the date stated above.							
22a. SIGNATURE Edward E. Morse				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> 10/11/60		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Edward E. Morse, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 14, 1960		23c. NAME OF CEMETERY OR CREMATORY National Memorial Park		23d. LOCATION (City, town, or county) (State) Falls Church, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Everly Funeral Home By Manager				25a. REC'D BY REGISTRAR OCT 13 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

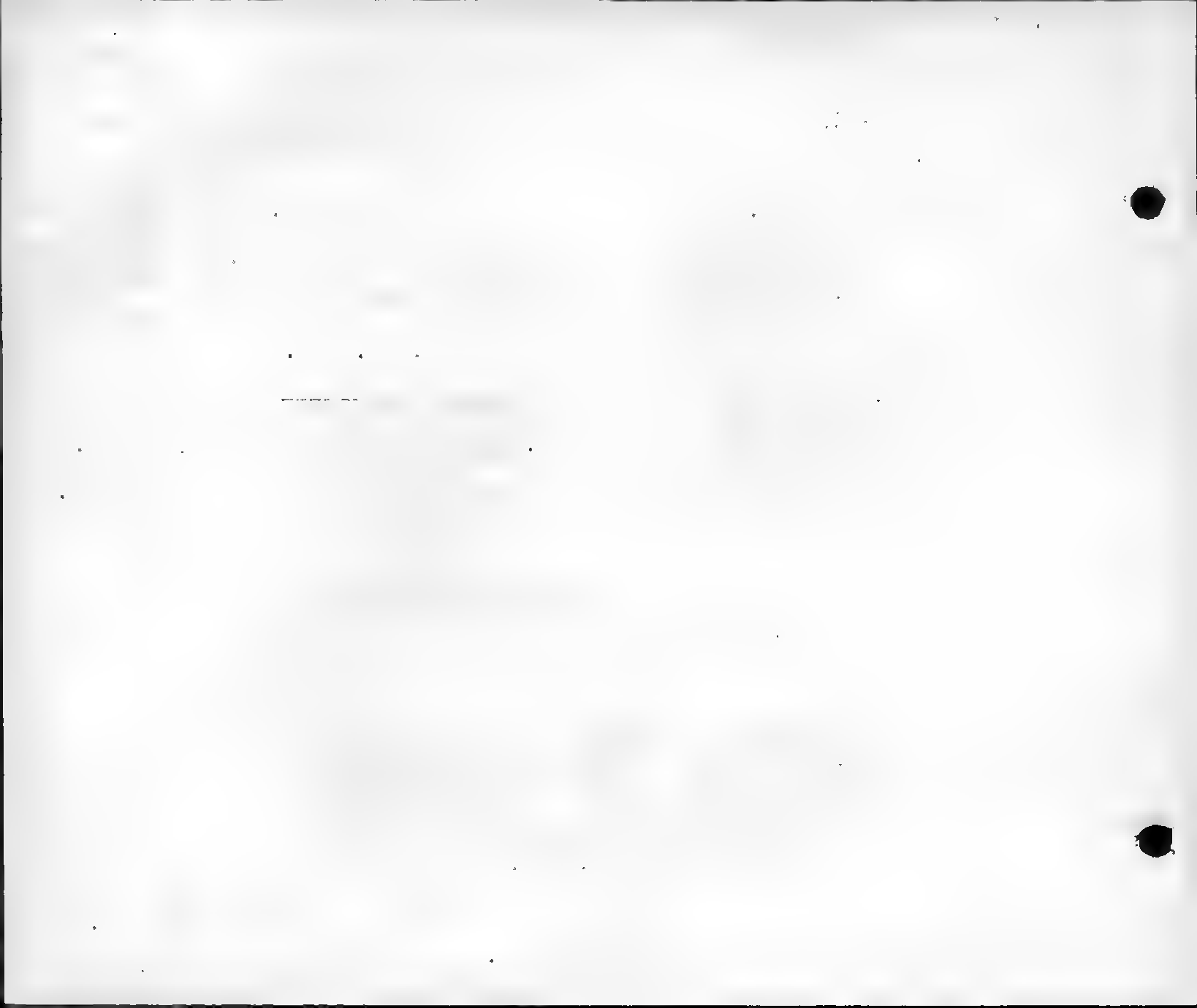


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 11603
 CERTIFICATE OF DEATH

Reg. Dist. No. 11546

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Damascus</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Damascus</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>26550 Ridge Rd.</u>				d. STREET ADDRESS <u>1 26550 Ridge Rd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Della Elizabeth Grimes</u>				4. DATE OF DEATH Month Day Year <u>Oct. 21 19 60</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 22, 1883</u>		9. AGE (In years lost birthday) <u>77</u> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Montg. Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Lyddard</u>				14. MOTHER'S MAIDEN NAME <u>Rachel Lyddard Hobbs</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>		INFORMANT Address <u>Mr. Glenn W. Grimes, Rockville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4-1-1</u> DUE TO <u>Ventricular Fibrillation</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				(b) <u>Coronary Artery Occlusion</u> 1959			
				(c) <u>Arteriosclerosis, generalized</u> ??			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus, severe; cataracts</u>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>					
20c. TIME OF INJURY Month. Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January</u> , 19 <u>60</u> , to <u>Oct. 22</u> , 19 <u>60</u> that I last saw the deceased alive on <u>Oct 22</u> , 19 <u>60</u> , and that death occurred at <u>6:25 PM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Gilcin F. Meadors</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>Main Street Oct 22 1960</u>			
PHYSICIAN'S NAME (Type) <u>Gilcin F. Meadors, M.D.</u>				<u>Damascus, Maryland</u>			
22a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 24, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Upper Seneca Baptist</u>		22d. LOCATION (City town, or county) (State) <u>Cedar Grove Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Oliver L. Moleman</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 25 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>	

MEDICAL CERTIFICATION



11604

11547

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE		Maryland		b. COUNTY		Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN IB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)							
Bethesda		35 Days		Bethesda 14							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Suburban				Landon School							
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month Day Year	
Robertson						Griswold, JR.		October 31		19 60	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
Male		White				10/1/20		49			
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
Teacher		Landon School		Maryland		U.S.A.					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME									
Robertson		Griswold		Abbie Roberts							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT		Address					
yes		157-1		Sloan Griswold		Bethesda-3, Md					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE FATAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
157-1		DUE TO		DUE TO							
Conditions, if any, which gave rise to immediate cause (a); stating the underlying cause last		(b)		(c)							
Acute pericarditis				Esophageal pleurocardial fistula							
Carcinoma of Esophagus											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
19											
21. I certify that (I) (this hospital) attended the deceased from Aug. 15, 1960, to Oct. 31, 1960, that (I) (we) last saw the deceased alive on Oct. 31, 1960, and that death occurred at 3:04 PM, from the causes and on the date stated above.											
22a. SIGNATURE		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS					
John H. Tuohy		10/31/60		John H. Tuohy		7720 WISCONSIN AVE BETHESDA 14, MD					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)					
Cremation		11/1/60		Loudon Park Crematory		Baltimore, Maryland					
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Wm. J. Tichauer		Bethesda-17, Md.		DATE Nov 2 '60		Arthur S. Kraus					



11550

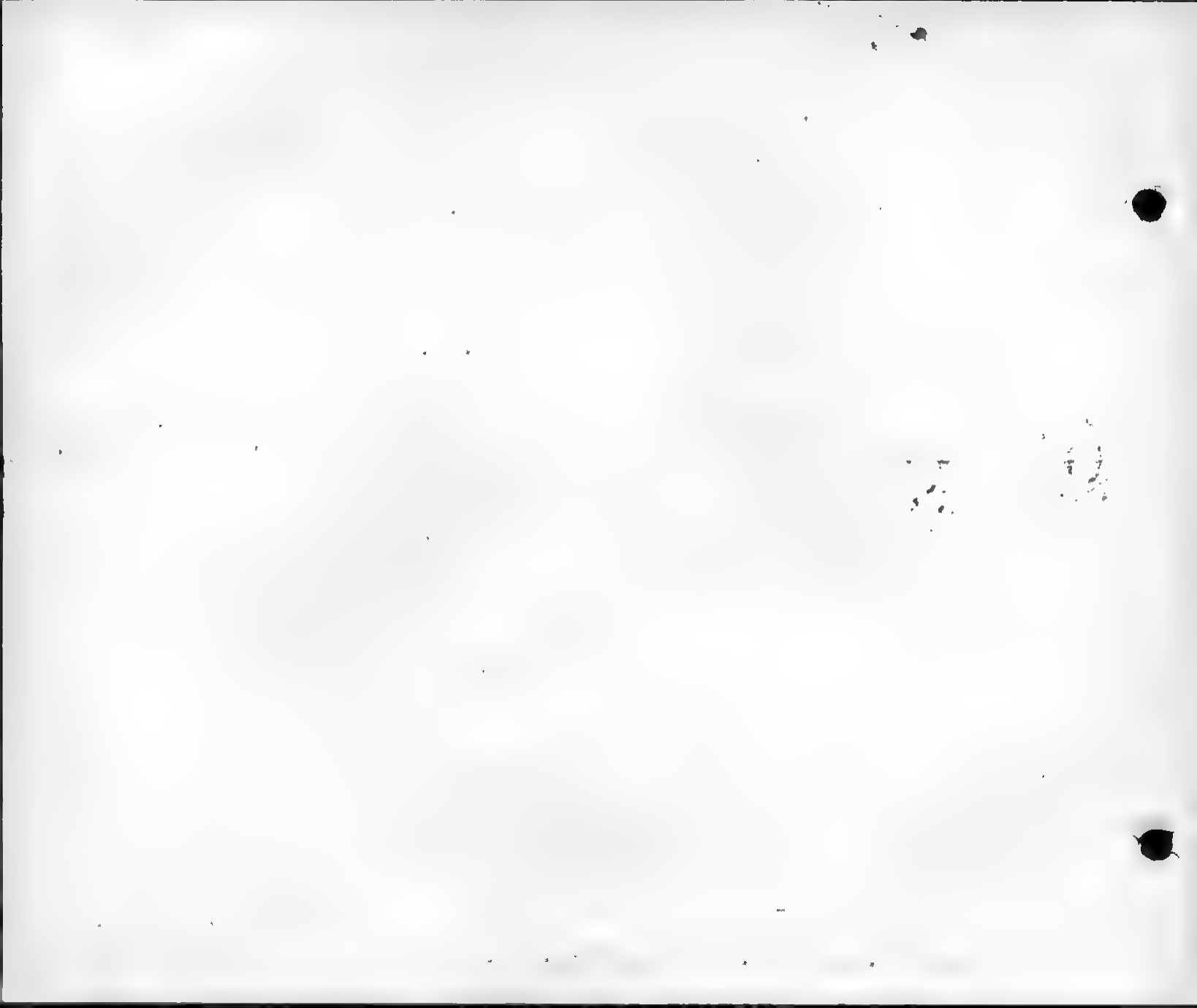
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montg. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montg	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. LENGTH OF STAY IN TB 10Yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Residence		e. STREET ADDRESS 210. Hutton St.	
3. NAME OF DECEASED (Type or print) First Hewitt Middle Duvall Last Grove		4. DATE OF DEATH Month Oct Day 14 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 27-1879
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 9 Days 17	11. IF UNDER 24 HRS Hours 17 Min 17
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired R.R. Conductor.		10b. KIND OF BUSINESS OR INDUSTRY W.Va.	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Thomas Grove		14. MOTHER'S MAIDEN NAME Susan Duvall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO INFORMANT	
17. ADDRESS Mrs Josephine Pulliam, Gaithersburg, Md		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 402.2 DUE TO Chronic Myocarditis Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. Multiple Myeloma. DUE TO 5 years. 2 years.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NO		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1957 , 19 10/14 , 19 60 , that I last saw the deceased alive on Oct 10 , 19 60 , and that death occurred at 5 A.M. , from the causes and on the date stated above ADDRESS (Street, city, or town, state) Gaithersburg, Md DATE SIGNED Ernest C. Gartner			
ACTUAL SIGNATURE Luciano L. Leal M.D. Gaithersburg, Md			
PHYSICIAN'S NAME (Type) Luciano L. Leal			
22a. BURIAL, CREMATION, REINTERMENT (Specify) Burial	22b. DATE THEREOF 10-14-60	22c. NAME OF CEMETERY OR CREMATORY Elwood Cemetery	22d. LOCATION (City, town, or county) (State) Shepherdstown, W.Va.
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner, Gaithersburg, Md.		24a. REC'D BY REGISTRAR DATE OCT 17 60	24b. REGISTRAR'S SIGNATURE Arthur S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)
15M 9/59

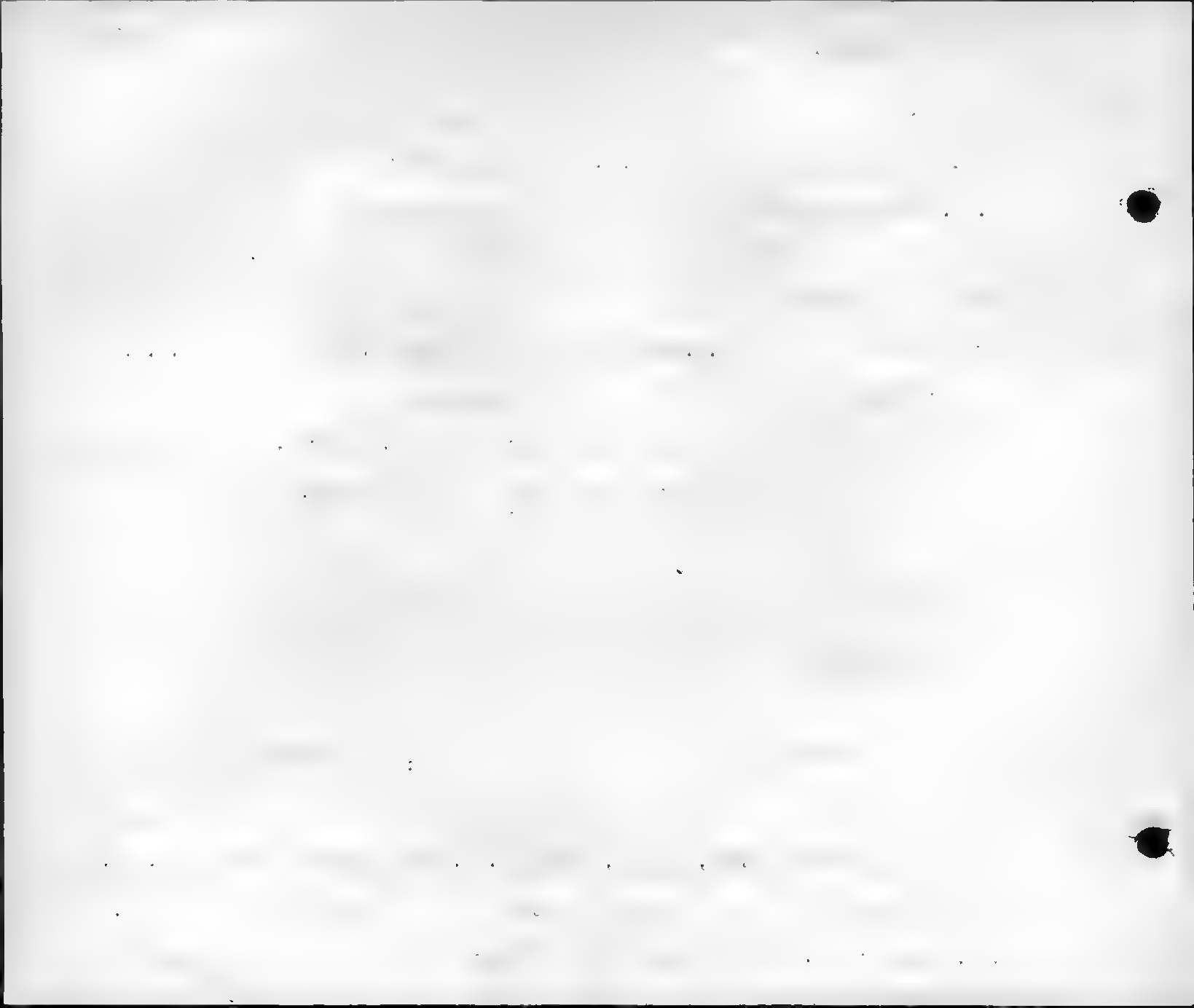
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11605

11549

1. PLACE OF DEATH COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY IN lb 37 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Markleysburg		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS RD #1, Box 17		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Harry		First Harry Middle GUTHRIE Last GUTHRIE		4. DATE OF DEATH Month October Day 5 Year 19 60			
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-16-34		9. AGE (In years last birthday) 26 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Armed Forces		10b. KIND OF BUSINESS OR INDUSTRY U.S. Marine Corp		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Junior GUTHRIE				14. MOTHER'S MAIDEN NAME Gladys COLE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO 180-26-4548		17. INFORMANT Address (W) Mrs. Irene E. Guthrie, same as #2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Widespread hemorrhage, gastrointestinal, genito-urinary and pulmonary DUE TO 292.4 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) APLASTIC ANEMIA DUE TO 666.65 (c) 666.65							INTERVAL BETWEEN ONSET AND DEATH 666.65
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) physician attended the deceased from August 29 1960 to October 5 1960 , that (I) yes last saw the deceased alive on October 5 1960 , and that death occurred at 10:43 PM , from the causes and on the date stated above.							
22a. SIGNATURE Russell Miller, LT, MC, USN				22b. DATE SIGNED 10-6-60		22c. PHYSICIAN'S NAME (Type) Russell MILLER, LT, MC, USN	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial-Shipment		23b. DATE THEREOF 10-6-60		23c. NAME OF CEMETERY OR CREMATORY Thomas Cemetery		23d. LOCATION (City, town, or county) (State) Markleysburg Pa.	
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers				25a. REC'D BY REGISTRAR DATE OCT 10 '60		25b. REGISTRAR'S SIGNATURE James P. Hume	

MEDICAL CERTIFICATION



11531

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11550

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakewood PARK</u>				c. LENGTH OF STAY IN 1b <u>4 months 26 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium and Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Austin</u> Middle <u>Lamont</u> Last <u>Haggerty</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>31</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 26, 1873</u>	
9. AGE (In years last birthday) <u>87 yrs.</u>		IF UNDER 1 YEAR Months <u>8</u> Days <u>7</u> Hours <u>18</u> Min. <u>0</u>		IF UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman - Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Theodore Haggerty</u>				14. MOTHER'S MAIDEN NAME <u>Julia Lamont</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Washington Sanitarium and Hospital</u>			
17. INFORMANT Address <u>Washington Sanitarium and Hospital</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Failure</u> 151X DUE TO (b) <u>Paraneoplastic Stomach Metastases</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. DUE TO (c) <u>Pelvic Lumbosacral Radiculopathy</u> INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs since April 18, 1960</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arterio Sclerotic C.V. Disease</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>April 18, 1960</u> to <u>Oct. 31, 1960</u> , that (I) (we) last saw the deceased alive on <u>Oct. 30, 1960</u> , and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above							
22a. SIGNATURE <u>Paul Janet M.D.</u> M.D. ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 10-31-60							
22c. PHYSICIAN'S NAME (Type) <u>PAUL JANET M.D.</u> 22d. ADDRESS <u>6727-16th St. N.W., Wash. D.C.</u>							
23a. REMOVAL INFORMATION REMOVAL (Specify) <u>removal</u> 23b. DATE THEREOF <u>11/2/60</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Oakland Cemetery</u> 23d. LOCATION (City, town, or county) (State) <u>Oakland, New Jersey</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co., 2901 14th St. N.W., Wash. D.C.</u> ADDRESS <u>Wash. D.C.</u> 25a. REC'D BY REGISTRAR <u>NOV 1 '60</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

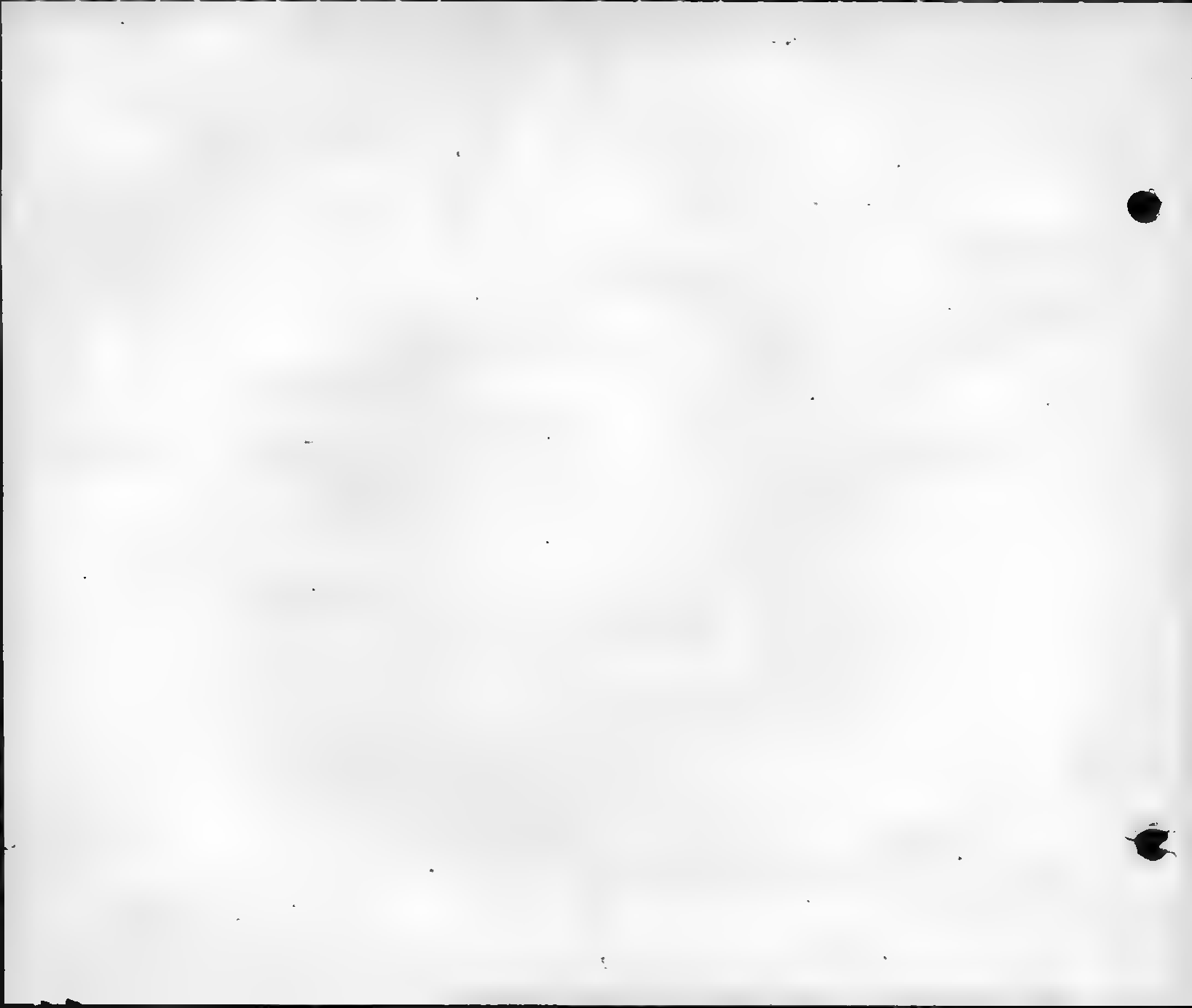
VR A15 (4)
ISM 9/59

11606

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11551

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 25 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8227 Wisconsin Avenue		d. STREET ADDRESS 8227 Wisconsin Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Louise Last Hand		4. DATE OF DEATH Month October Day 10/29 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/10/1905
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months 8 Days 19 Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurant Owner		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Charles W. Archer		14. MOTHER'S MAIDEN NAME Nellie Gray	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO Yes	
17. INFORMANT James Hand-Husband-same as 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiovascular collapse DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) myocardial infarction DUE TO arteriosclerotic heart disease (c) 3 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) exogenous obesity 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1957 to Oct 1960 that (I) (we) last saw the deceased alive on Oct 21 1960 and that death occurred at 9:50 AM , from the causes and on the date stated above.			
22a. SIGNATURE Wilfred R. Ehrmantant M.D.		22b. DATE SIGNED 10/29/60	
22c. PHYSICIAN'S NAME (Type) Wilfred R. Ehrmantant M.D.		22d. ADDRESS 4890 Battery Lane, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/1/60	
23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City, town, or county) (State) Rockville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25a. REC'D BY REGISTRAR DATE NOV 2 '60	
ADDRESS Bethesda, Maryland		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

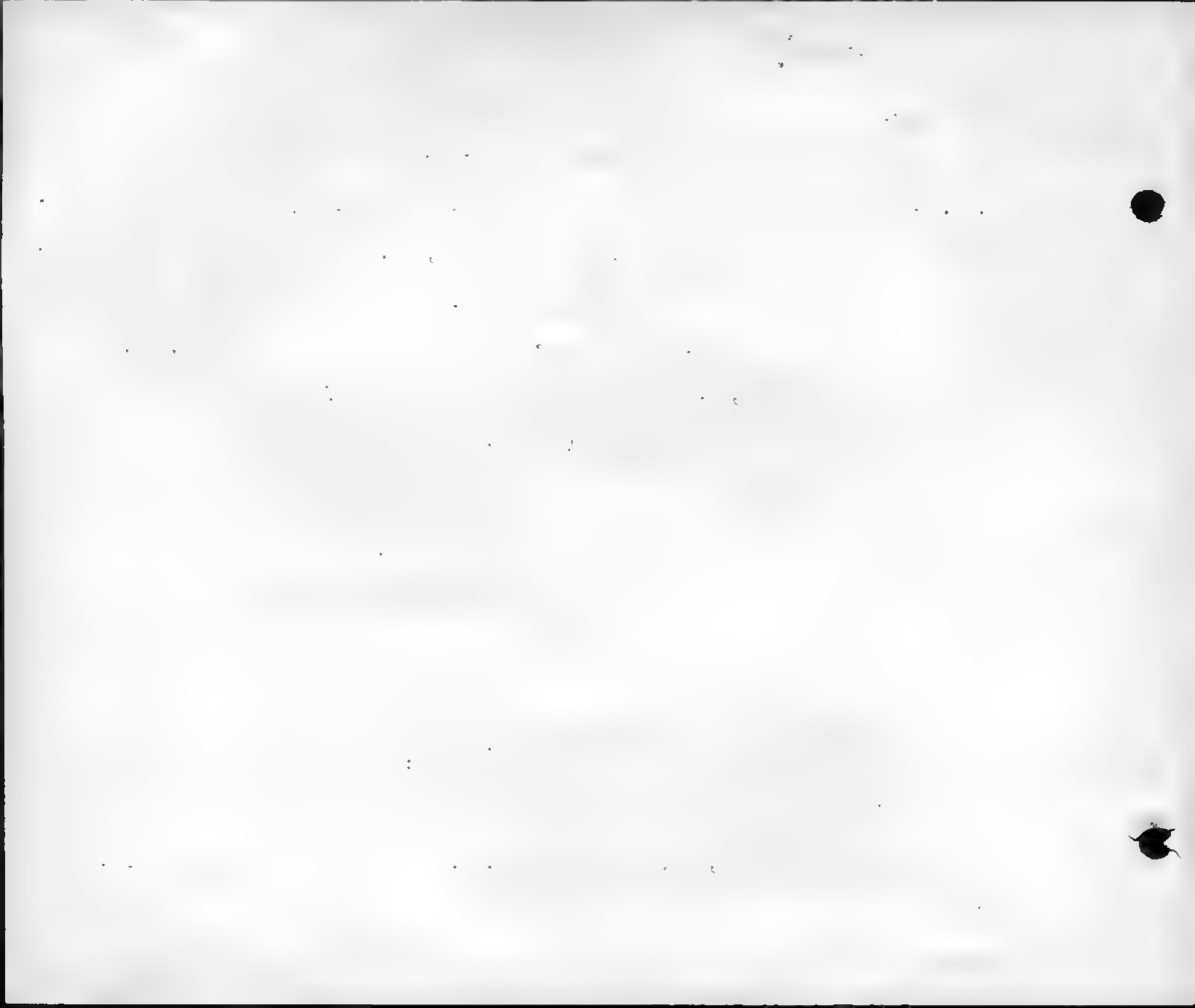
VR A15 (4)
15M 9/59

11607

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11552

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 24 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Virginia b. COUNTY Alexandria c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria d. STREET ADDRESS 500 N. Kings Highway e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Ernest Middle Linnwood Last HARLOW, JR.		4. DATE OF DEATH Month October Day 31 Year 19 60				
5 SEX Male	6. COLOR OR RACE Caucasian	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9-1-20	9 AGE (In years last birthday) 40 yrs	10 IF UNDER 1 YEAR Months 4 Days 4 Hours 4 Min.	11 IF UNDER 24 HRS Hours 4 Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman		10b. KIND OF BUSINESS OR INDUSTRY Alex., Va. Fire Dept.		11 BIRTHPLACE (State or foreign country) Virginia		12 CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Ernest Linnwood HARLOW, SR.		14. MOTHER'S MAIDEN NAME Ellen Evelyn OSBORNE				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 1941-1945		17 INFORMANT (W) Mrs. Agnes L. Harlow, same as #2 above		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 204 DUE TO Intracerebral hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Acute myelogenous leukemia (c) 4 days 4 mos.						INTERVAL BETWEEN ONSET AND DEATH 4 days 4 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)
21. I certify that (I) (we) attended the deceased from Oct. 7 19 60 to Oct. 31 19 60 that (I) (we) last saw the deceased alive on Oct. 31 19 60 , and that death occurred at 11:20AM M, from the causes and on the date stated above.						
22a SIGNATURE Russell Miller, LT, MC, USN		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b DATE 10-31-60		
22c PHYSICIAN'S NAME (Type) Russell MILLER, LT, MC, USN		22d ADDRESS U. S. Naval Hospital, Bethesda, Md.				
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 11-4-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d LOCATION (City, town, or county) (State) Arlington Virginia
24. FUNERAL DIRECTOR'S SIGNATURE Cunningham Funeral Home, Alexandria, Va.		ADDRESS W. Sewley Mountkath		25a RECORDING REGISTRAR'S SIGNATURE NOV 4 '60		25b REGISTRAR'S SIGNATURE W. Sewley Mountkath

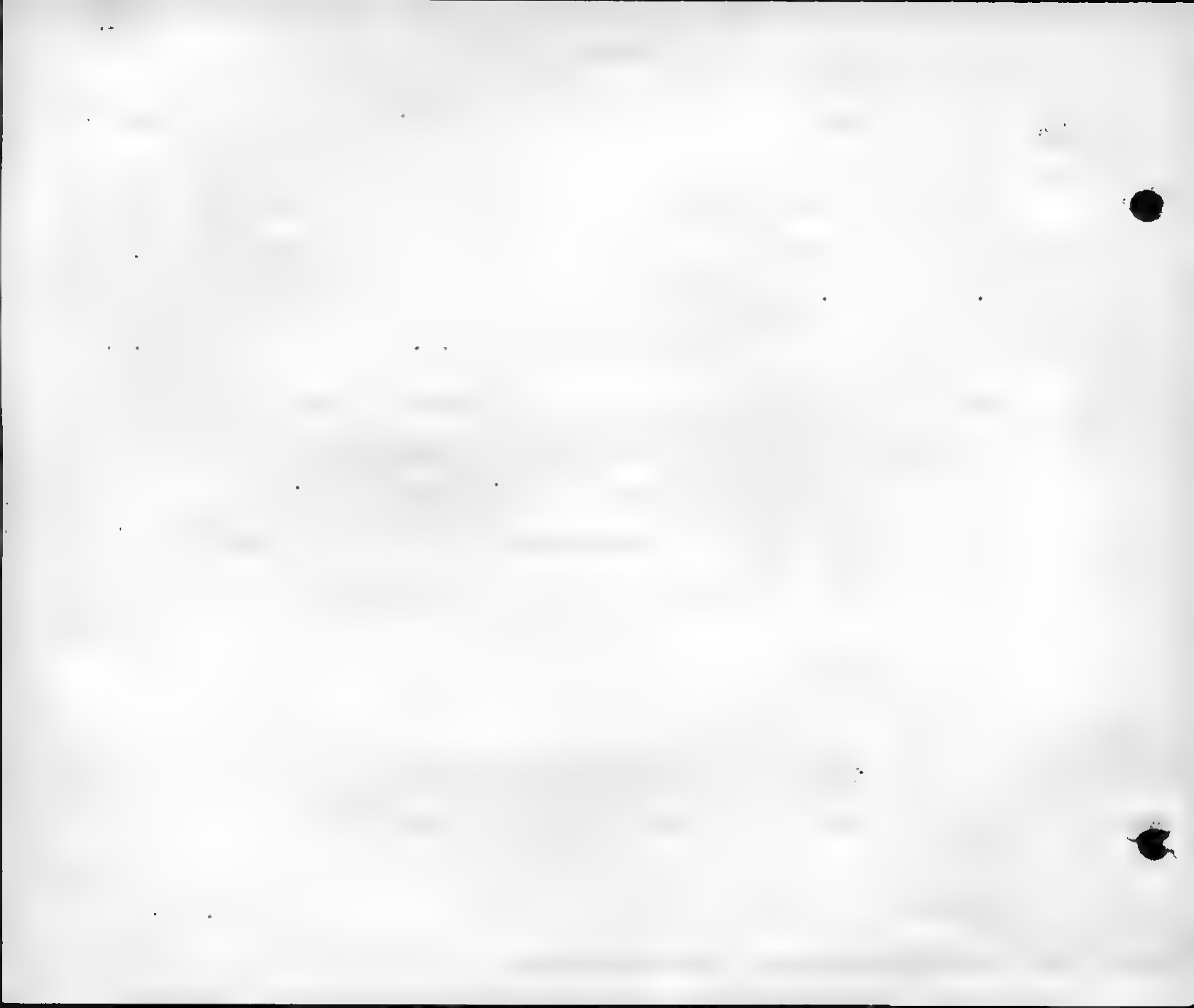


CERTIFICATE OF DEATH

Reg. Dist. No.

11507

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) Philomena Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Marie Middle Harrington Last Harrington		4. DATE OF DEATH Month October Day 14th Year 1960	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 5th. 1877
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months 83 Days 83 Hours 83 Min 83	11. IF UNDER 24 HRS Months 83 Days 83 Hours 83 Min 83
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY School teacher	
11. BIRTHPLACE (State or foreign country) N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Winfield F Overton		14. MOTHER'S MAIDEN NAME Myra Fordham	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO (If yes, give war or dates of service) INFORMANT Mrs Helen Vierling Address Washington D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 12 Congestive Heart Failure DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) 20 years		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. Day 19 Year 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov 2, 1959 to Oct 14, 1960 that I last saw the deceased alive on Oct 5, 1960 , and that death occurred at 7:15 PM , from the causes and on the date stated above ADDRESS (Street, city or town, state) 5527 Surrey St. Washington D.C. DATE SIGNED Oct 18 '60			
ACTUAL SIGNATURE Harry J. Fisher M.D.		DATE SIGNED Oct 18 '60	
PHYSICIAN'S NAME (Type) H. J. Fisher		ADDRESS Cherry Chase, Md.	
22a. BURIAL CREMATON, REMOVAL (Specify) Cremation	22b. DATE THEREOF 10-15-60	22c. NAME OF CEMETERY OR CREMATORY Lee's Crematorium	22d. LOCATION (City, town, or county) (State) Washington D.C.
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home - Washington D.C.		24. REC'D BY REGISTRAR OCT 18 '60	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

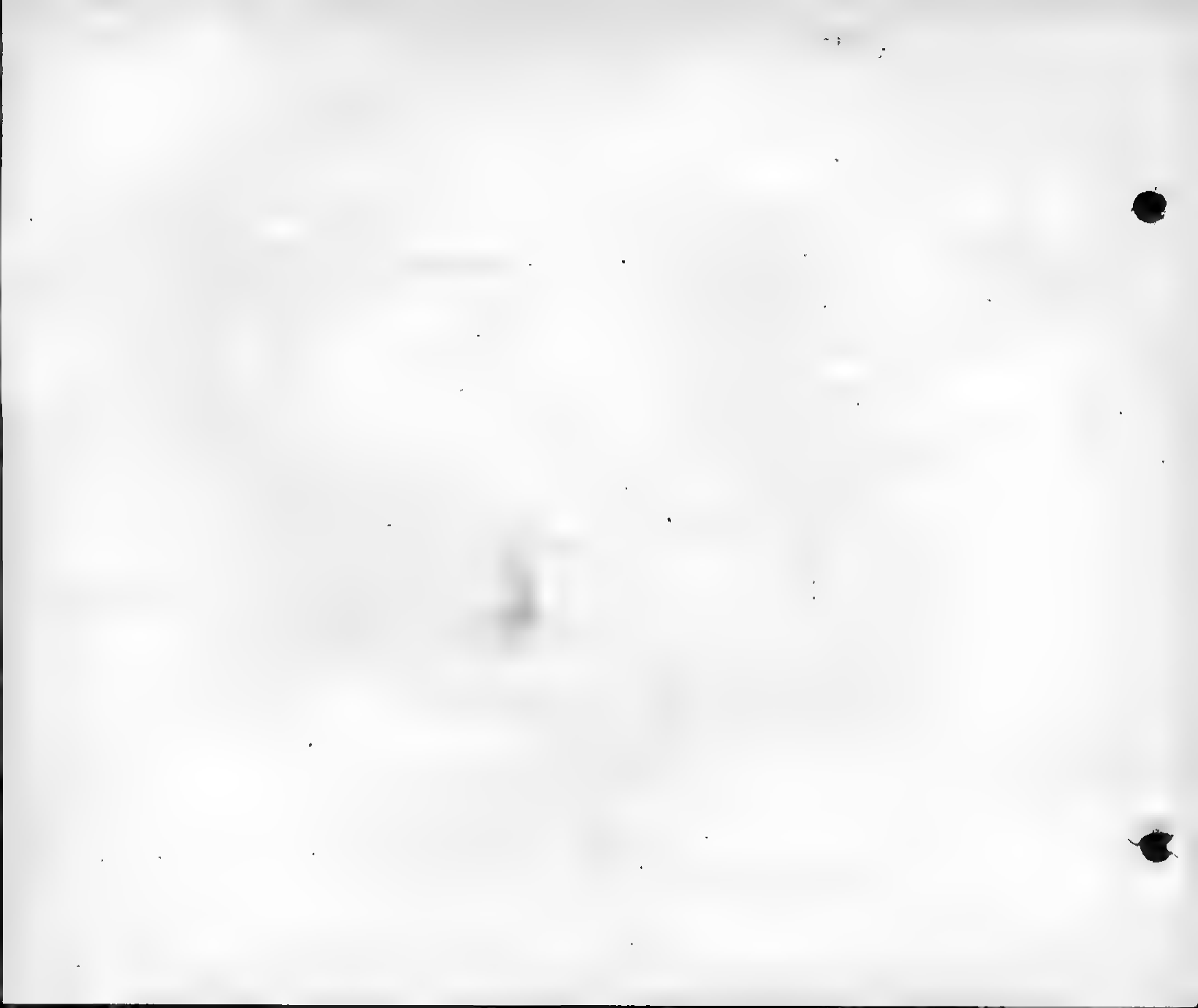
VR AIS (4)
ISM 9/59

11608

STATE OF MARYLAND
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11554

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>6 years.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5714 Kingswood Rd</u>		d. STREET ADDRESS <u>15714 Kingswood Rd.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last <u>Florence Amanda Harrison</u>		4. DATE OF DEATH Month Day Year <u>October 17 1966</u>	
5. SEX <u>Female</u>	6 COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Nov. 16, 1933</u>
9. AGE (In years lost birthday) <u>76</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Frank Leatherwood</u>		14 MOTHER'S MAIDEN NAME <u>Rose Day.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17 INFORMANT <u>Mary Louise Montgomery, 5714 Kingswood Rd</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia.</u> DUE TO <u>175.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Adenocarcinoma of ovary</u> DUE TO <u>—</u> (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>9 months</u>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d INJURY OCCURRED While <input checked="" type="checkbox"/> at work No while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>Sept. 13, 1966</u> to <u>October 17, 1966</u> that (I) <u>(we)</u> last saw the deceased alive on <u>October 17, 1966</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above			
22a SIGNATURE <u>Charles W. Humphreys, Jr. M.D.</u>		22b DATE SIGNED <u>10/17/66</u>	
22c PHYSICIAN'S NAME (Type) <u>Charles W. Humphreys, Jr. M.D.</u>		22d ADDRESS <u>1746 K St. N.W., Wash. D.C.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial October 20, 1966</u>		23b DATE THEREOF <u>October 20, 1966</u>	
23c NAME OF CEMETERY OR CREMATORY <u>MORGAN CHAPEL Cemetery</u>		23d LOCATION (City, town, or county) (State) <u>CARROLL County, Md.</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>E. M. WALTZ</u>		25a REC'D BY REGISTRAR <u>Wenfield, Maryland</u>	
25b REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>		DATE <u>OCT 19 '60</u>	



11609

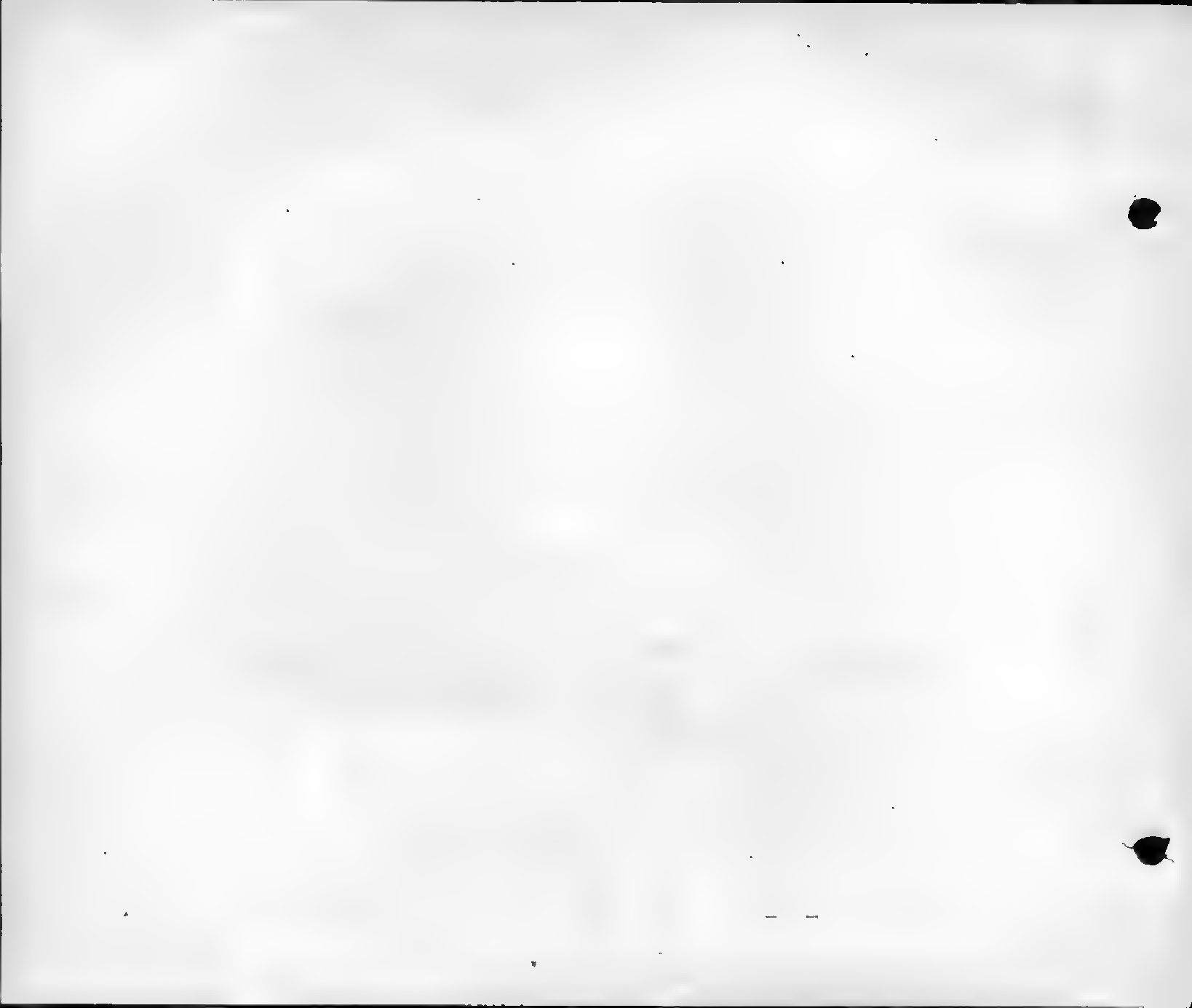
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

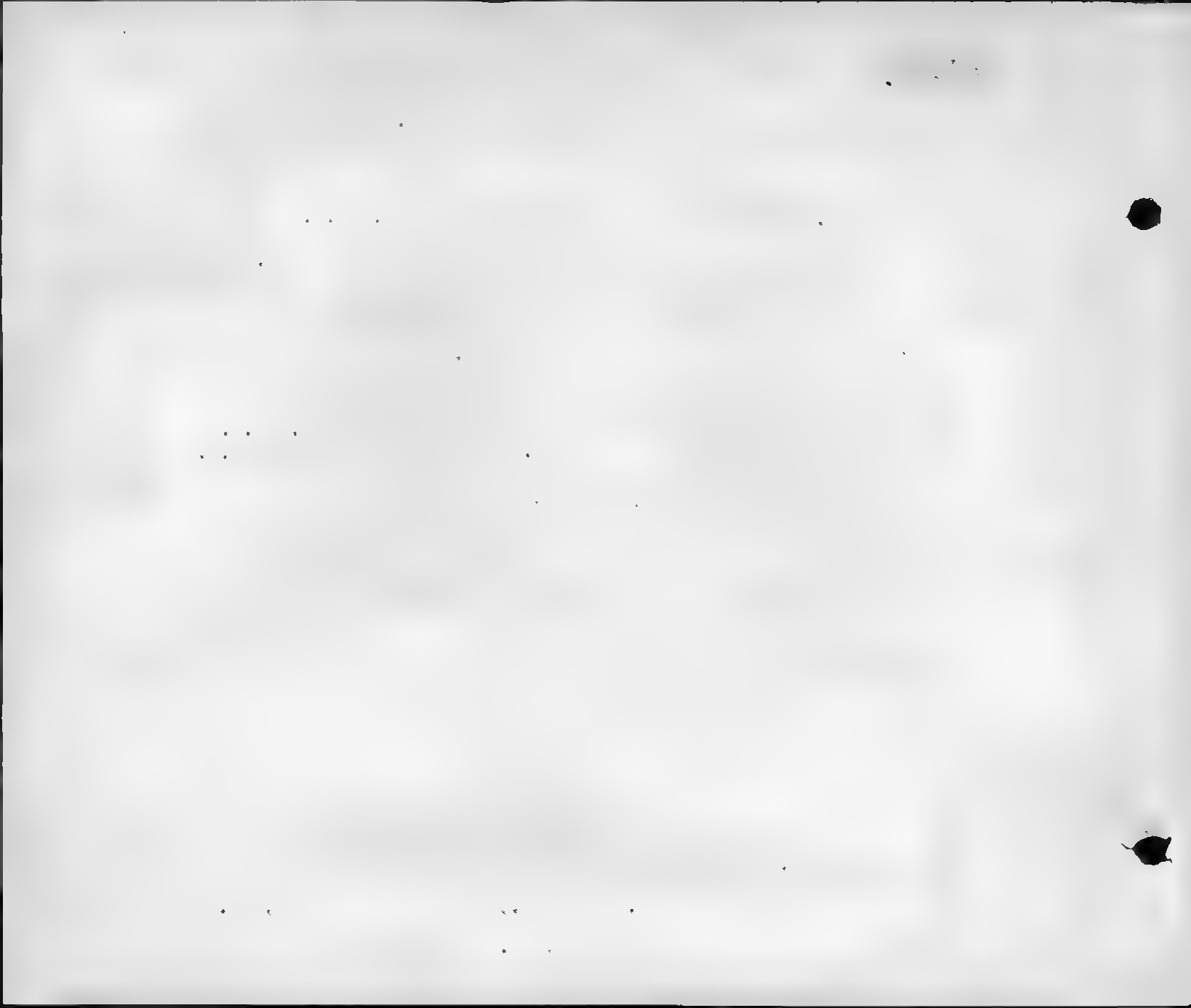
11555

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Olney</i>				c. LENGTH OF STAY IN 1b <i>1 yr 5 mo</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Brooke Grove Foundation</i>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sil. Sp.</i>			
f. STREET ADDRESS <i>13210 Columbia Pike</i>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Katherine E. Hazen</i>				4. DATE OF DEATH <i>Oct 15 1960</i>			
5. SEX <i>female</i>		6. COLOR OR RACE <i>cauc</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Feb 20 1859</i>	
9. AGE (In years last birthday) <i>101</i> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Brookeville, md.</i>			
13. FATHER'S NAME <i>Wm Easton</i>				14. MOTHER'S MAIDEN NAME <i>Margaret</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> If yes, give war or dates of service				16. SOCIAL SECURITY NO. <i>none</i>			
17. INFORMANT <i>Mrs. George W. Graham</i>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Apoplexy, thrombosis</i> 420 - DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis heart disease</i> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <i>1 hr</i> <i>20 yrs</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>Jan 1950</i> to <i>Oct 1960</i> that (I) (we) last saw the deceased alive on <i>Sept 1960</i> , and that death occurred at <i>3:30 PM</i> , from the causes and on the date stated above.							
22a. SIGNATURE <i>A.D. Bonifant</i>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <i>A.D. BONIFANT</i>				22d. ADDRESS <i>Farmington, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>10-18-60</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Brookeville</i>		23d. LOCATION (City, town, or county) (State) <i>Brookeville Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Francis H. Barber</i>				25a. REC'D BY REGISTRAR DATE <i>OCT 19 '60</i>			
ADDRESS <i>Laytonville, Md.</i>				25b. REGISTRAR'S SIGNATURE <i>James L. Howard</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



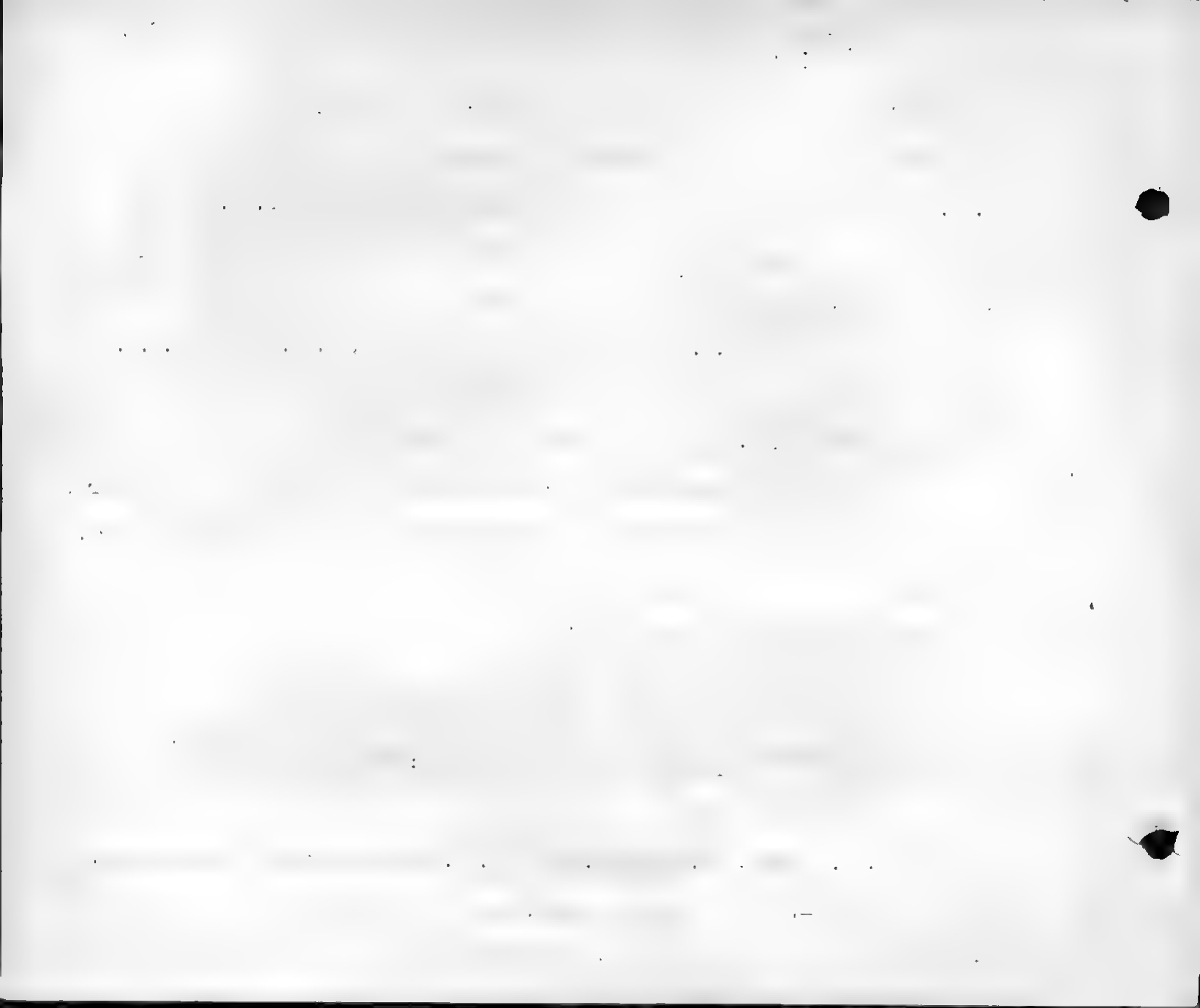


11610 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11557

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 10 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				e. STREET ADDRESS 2936 Cortland Place, N. W.			
3. NAME OF DECEASED (Type or print) First Samuel Middle Lutz Last HOWARD				4. DATE OF DEATH Month October Day 12 Year 1960			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-8-91	
9. AGE (In years last birthday) 69 yrs		10. IF UNDER 1 YEAR Months		11. IF UNDER 24 HRS Days		12. IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Officer				10b. KIND OF BUSINESS OR INDUSTRY U.S. Marine Corps		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Clement HOWARD				14. MOTHER'S MAIDEN NAME Addie LUTZ			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WWI-WWII-Kor.		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage, retroperitoneal 450 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis, generalized DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Encephalopathy due to arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 4 yrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) October 2 1960 to October 12 1960				(County) (State)			
21. I certify that (I) person attended the deceased from October 2 1960 to October 12 1960 , that (II) last saw the deceased alive on October 12 1960 , and that death occurred at 10:30 PM , from the causes and on the date stated above.							
22a. SIGNATURE <i>G. I. Walker, Jr.</i>				M. D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-13-60	
22c. PHYSICIAN'S NAME (Type) G. I. WALKER, JR., CAPT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-17-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Gawler</i>				25a. REC'D BY REGISTRAR OCT 17 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Gawler</i>	

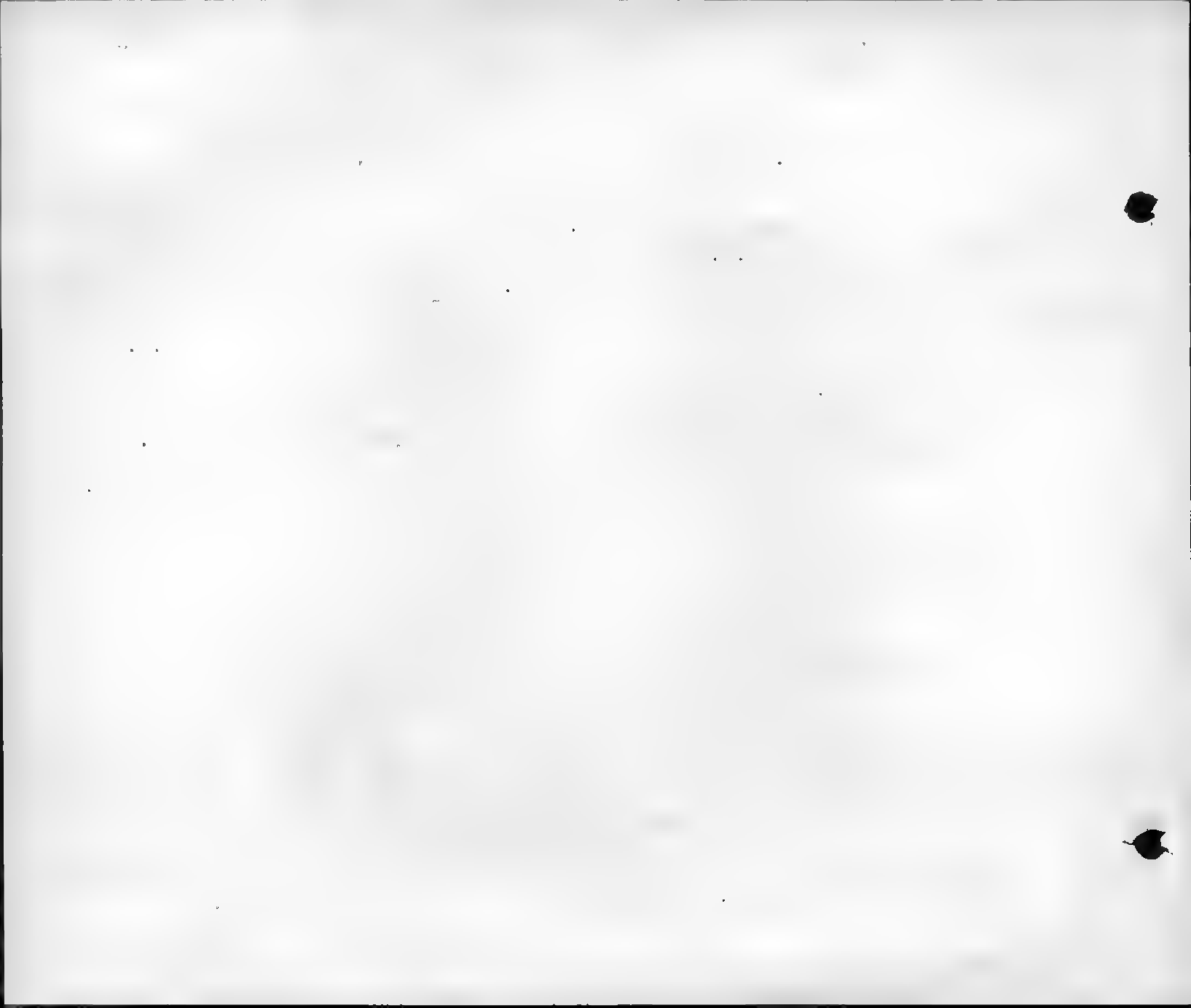
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



11611
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11558

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 9124-McDonald Dr. Bethesda, Md c. LENGTH OF STAY IN lb 13yrs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dickerson, Md d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Franklin James XXXXXXHYEX Last HOYLE				4. DATE OF DEATH Month Oct Day 20 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 1-1870	
9. AGE (In years last birthday) 90 yrs		10. IF UNDER 1 YEAR Months 90 Days 0 Hours 0 Min 0		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired farm owner				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME Joseph Hoyle				14. MOTHER'S MAIDEN NAME Charlotte Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Joseph Hoyle, 4615-Creek Shore Dr. Rockville Address Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA DUE TO 12X Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CHRONIC NEPHRITIS DUE TO 14X (c) HYPERTENSION						INTERVAL BETWEEN ONSET AND DEATH 10 DAYS 2 yrs 15 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1955 to Oct 1960 , that (I) (we) last saw the deceased alive on Oct 18 19 60 and that death occurred at 7:30 A. M. from the causes and on the date stated above							
22a. SIGNATURE Leo I. O'Donovan M.D.		22b. ADDRESS 8214 WISC AVE BETHESDA MD		22c. PHYSICIAN'S NAME (Type)		22d. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 10/22/60		23c. NAME OF CEMETERY OR CREMATORY Monocacy		23d. LOCATION (City, town, or county) (State) Beallsville, Md	
24. FUNERAL DIRECTOR'S SIGNATURE William B. Hatten, Beallsville, Md				25a. REC'D BY REGISTRAR OCT 25 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hatten	

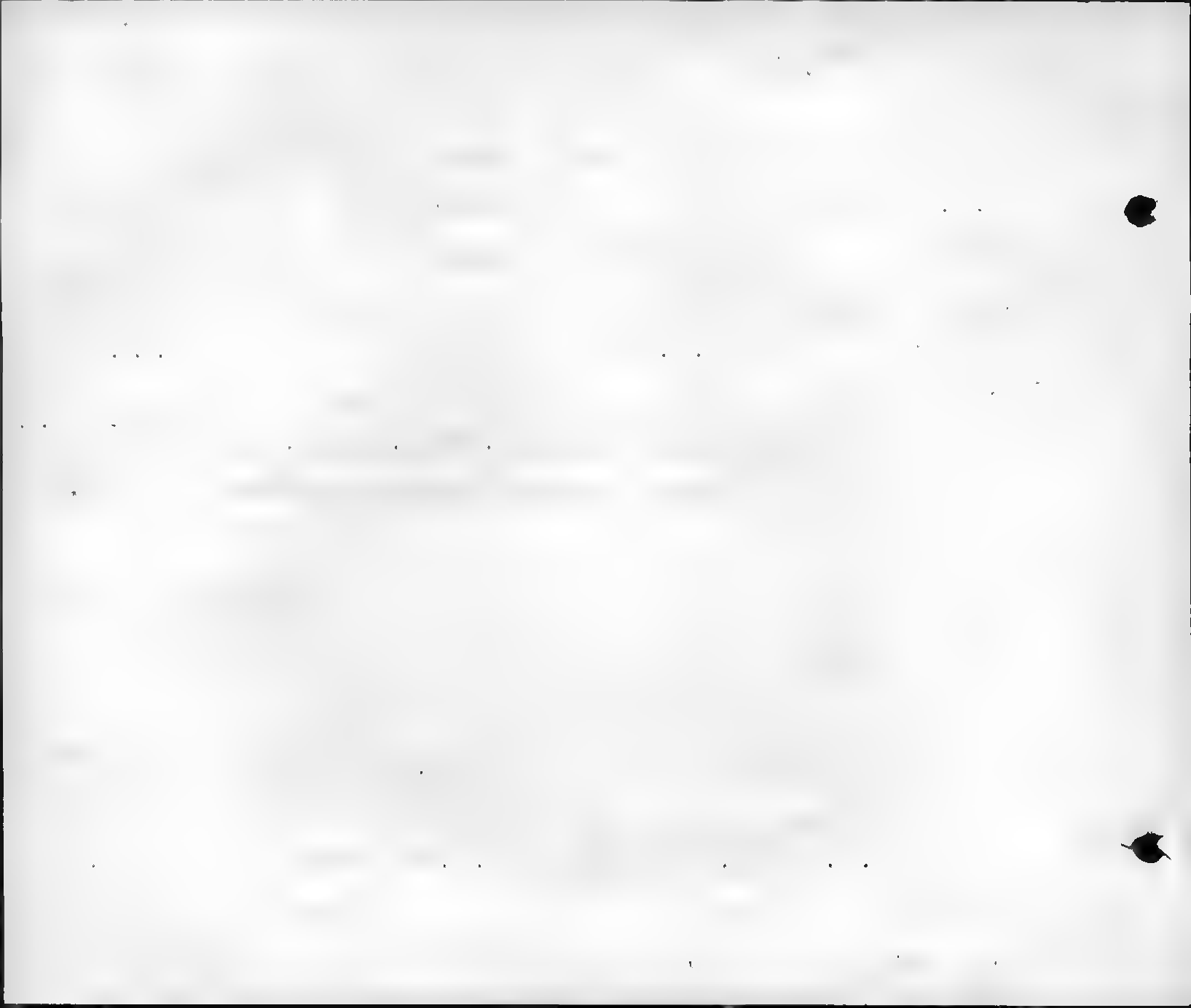


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

11612
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
11559

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE New York b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 53 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gouverneur	
d. STREET ADDRESS 150 Park Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Robert Middle Ernest Last HUNKINS		4 DATE OF DEATH Month October Day 12 Year 19 60	
5 SEX Male	6 COLOR OR RACE Caucasian	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-23-36
9 AGE (In years last birthday) 24 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Officer		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ernest HUNKINS		14. MOTHER'S MAIDEN NAME Lucille WELLS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 120-28-9482	
17. INFORMANT (W) Mrs. Elsa M. Hunkins, 101 Farnham Road,		Address Syracuse 4, N.Y.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma, chorionic, testes, with metastases DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 mos.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) the doctor attended the deceased from August 20, 1960 to October 12, 1960 , that (I) was lost saw the deceased alive on October 12 1960 , and that death occurred at 7:25AM , from the causes and on the date stated above.			
22a. SIGNATURE B. D. CASTEEL		22b. DATE SIGNED 10-12-60	
22c. PHYSICIAN'S NAME (Type) B. D. CASTEEL, CAPT MC USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment		23b. DATE THEREOF 10-14-60	
23c. NAME OF CEMETERY OR CREMATORY WashDC		23d. LOCATION (City, town, or county) (State) Gouverneur New York	
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Funeral Home, 1400 Chapin St., NW		25a. REC'D BY REGISTRAR OCT 14 '60	
25b. REGISTRAR'S SIGNATURE Charles E. Evans			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and at any event, within 72 hours after death.

VR A15 (4)
15M 9/59

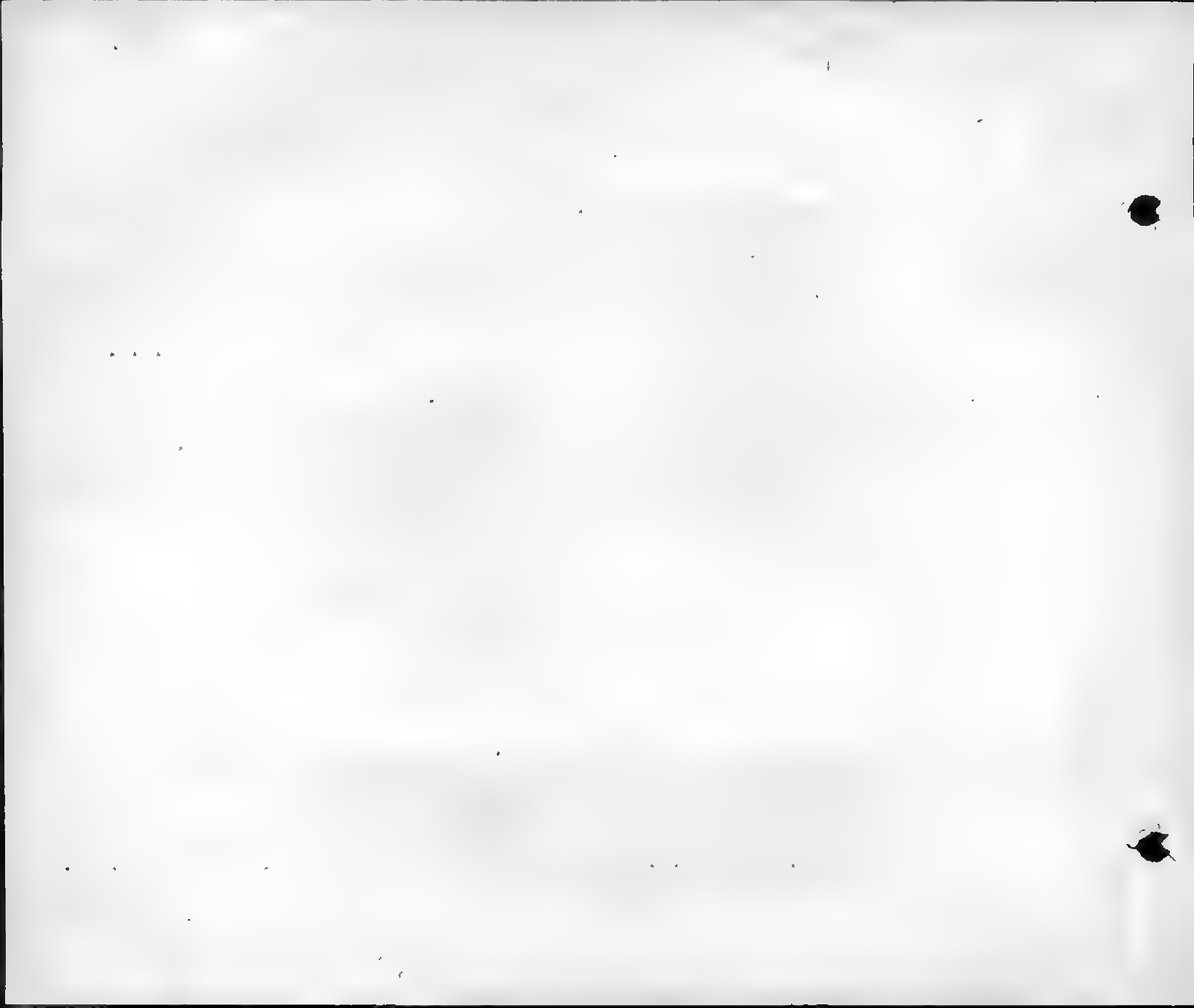
11613

11560

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 51 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE West Virginia b. COUNTY Madison c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Madison d. STREET ADDRESS 143 Nathan Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Carol Middle Jean Last Hunter		4. DATE OF DEATH Month October Day 23 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 15, 1930
9. AGE (In years last birthday) yrs 29		10. IF UNDER 1 YEAR Months 29 Days 29 Hours 29 Min. 29	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Casey		14. MOTHER'S MAIDEN NAME Leah Huddy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO Unascertainable	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute lymphocytic leukemia 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 14 months			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept. 2 1960 to October 23, 1960 , that (I) (we) last saw the deceased alive on October 23, 1960 , and that death occurred at 9:45 PM from the causes and on the date stated above.			
22a. SIGNATURE Edward E. Morse		22b. DATE 10/23/60	
22c. PHYSICIAN'S NAME (Type) EDWARD E. MORSE, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/27/60	23c. NAME OF CEMETERY OR CREMATORY Resor. Gardens	23d. LOCATION (City, town, or county) (State) Madison, W. Virginia
24. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler Funeral		25a. REC'D BY REGISTRAR Oct 26 '60	25b. REGISTRAR'S SIGNATURE Arthur S. Kline

11-5741-60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

11614

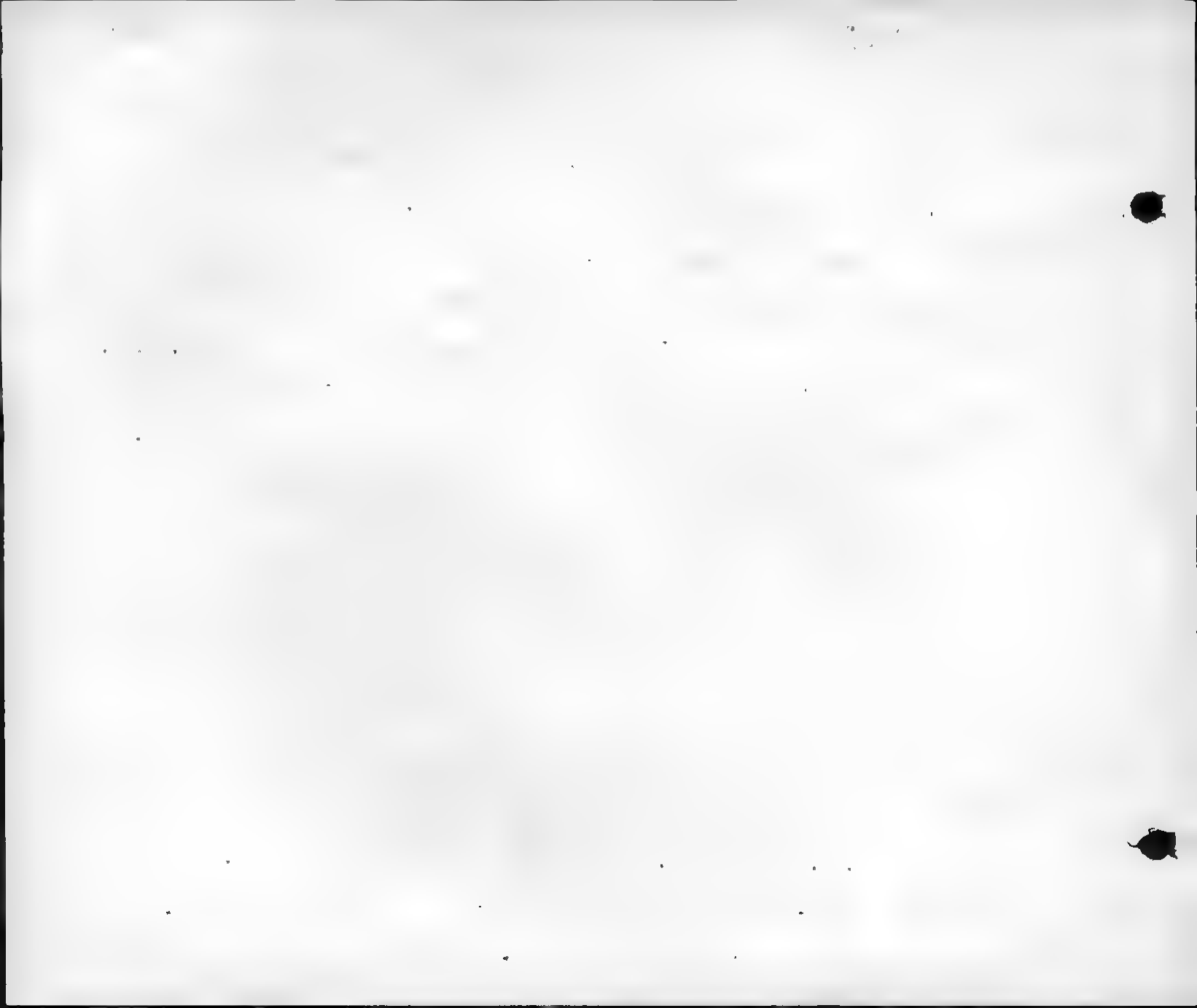
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11561

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GERMANTOWN					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL				d. STREET ADDRESS RT. 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LEAH Middle JANE Last IGLEHART				4. DATE OF DEATH Month OCTOBER Day 15 Year 1960					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/7/1874			
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) MARYLAND			
13. FATHER'S NAME NOAH WATKINS				14. MOTHER'S MAIDEN NAME JULIA LINTHICUM					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address HOSPITAL RECORDS, OLNEY, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism, bilateral DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Thrombus, right auricle DUE TO (c) Phlebotrombosis right leg PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus								INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 9/24/60 to 10/15/60 , that (I) (we) last saw the deceased alive on 10/15/60 , and that death occurred 9:40A from the causes and on the date stated above.									
22a. SIGNATURE C. H. LIGON, M. D.				M. D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type or print)				22d. ADDRESS SANDY SPRING, MD.					
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 18, 1960		23c. NAME OF CEMETERY OR CREMATORY Salem Methodist		23d. LOCATION (City, town, or county) (State) Cedar Grove, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber				ADDRESS Laytonsville, Md.		25a. REC'D BY REGISTRAR DATE OCT 19 '60			
						25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

M

1



11553

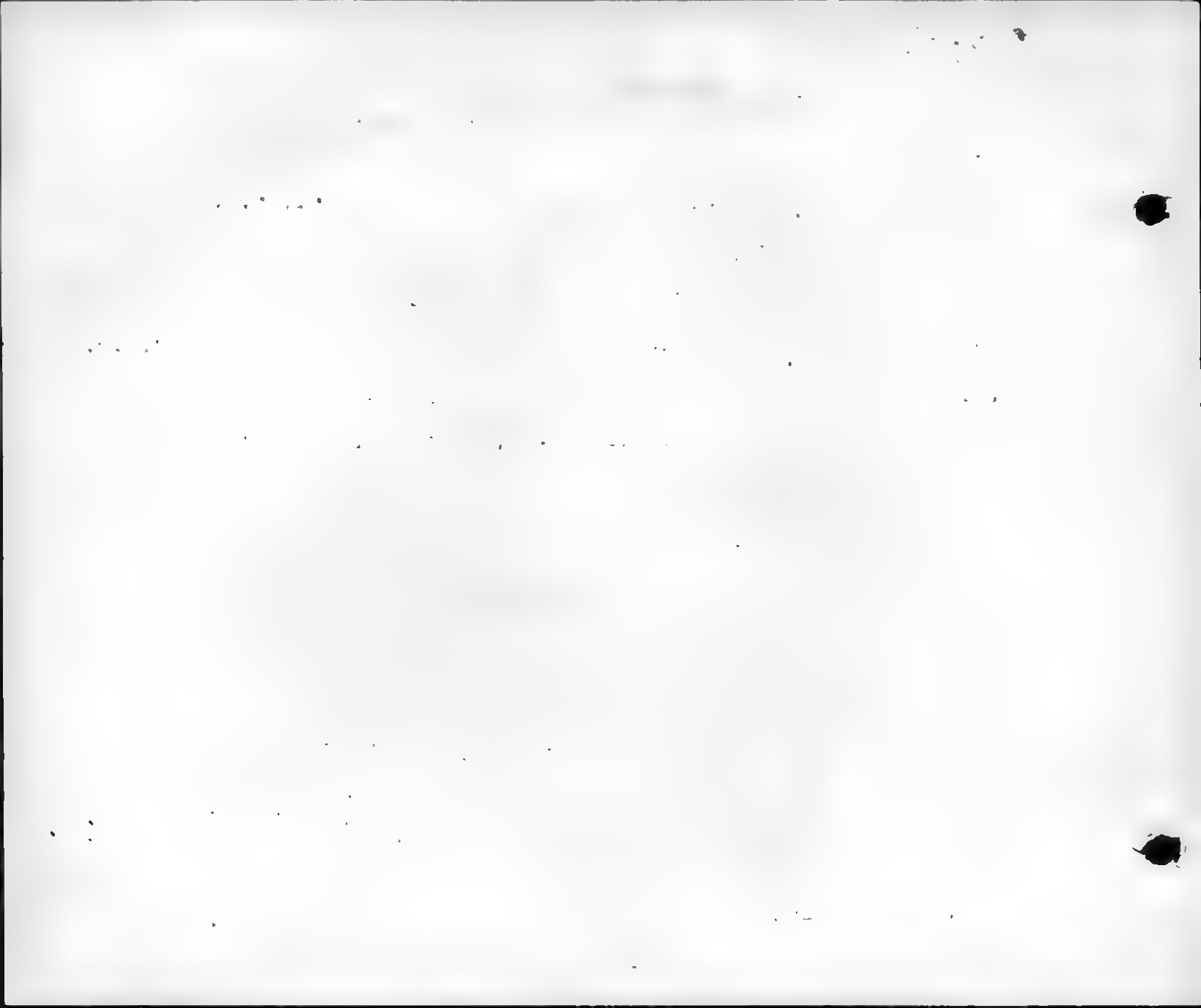
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> c. LENGTH OF STAY IN 1b <u>Carroll Hall Sanitorium</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carroll Hall Sanitorium</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Dist. of Col.</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>5545 Potomac Ave., N.W.</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MYRTLE</u> Middle <u>M.</u> Last <u>ILES</u>		4. DATE OF DEATH Month <u>OCTOBER</u> Day <u>31</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OF RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-20-1865</u>
9. AGE (In years last birthday) <u>94</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>A.B. Carl</u>		14. MOTHER'S MAIDEN NAME <u>Nancy Hunter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>-----</u>		16. SOCIAL SECURITY NO. <u>-----</u>	
INFORMANT <u>Mrs. Lester A. Pratt (Daughter)</u>		Address <u>-----</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARCINOMA OF BREAST</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>GENERALIZED CARCINOMATOSIS</u> DUE TO (c) <u>-----</u>		INTERVAL BETWEEN ONSET AND DEATH <u>-----</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SENILITY</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-----</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-----</u>		20f. (City or town) (County) (State) <u>-----</u>	
21. I certify that I attended the deceased from <u>FEB. 20, 1960</u> , to <u>OCT. 31, 1960</u> , that I last saw the deceased alive on <u>OCT. 31, 1960</u> , and that death occurred at <u>2:55 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Heinzen Fowden</u>		ADDRESS (Street, city or town, state) <u>5206 NORWAY DR</u>	
PHYSICIAN'S NAME (Type) <u>CHERY CHASE</u>		DATE SIGNED <u>10/31/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>11-2-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>-----</u>		22d. LOCATION (City, town, or county) (State) <u>Orlando, Fla.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Hawler's sons</u>		24a. REC'D BY REGISTRAR ADDRESS <u>1756 Pp. Dr. N.W.</u> DATE <u>NOV 3 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

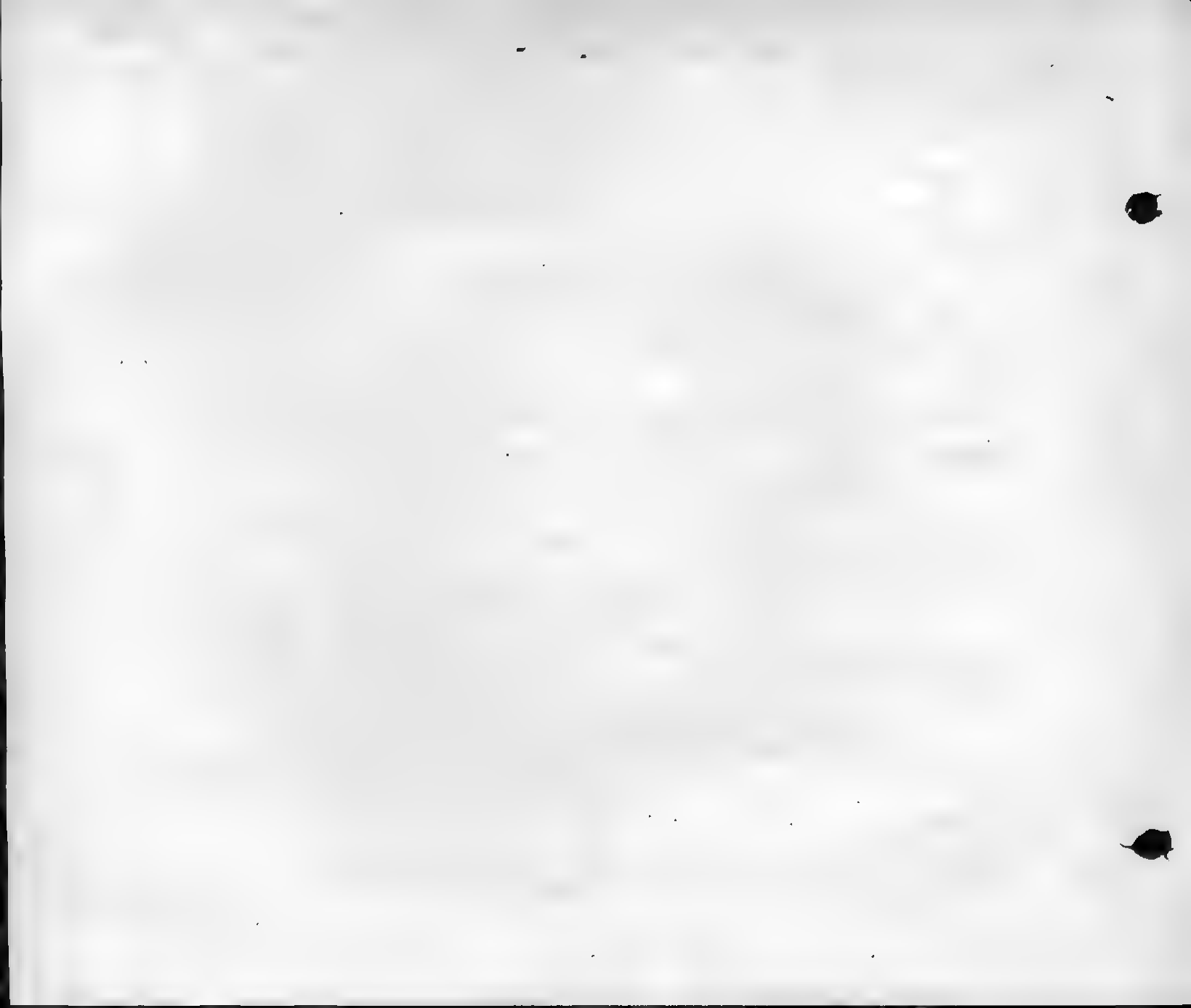
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11563

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Norfolk</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Norfolk</u>	
c. LENGTH OF STAY IN 1b <u>DOA</u>		d. STREET ADDRESS <u>309 West 28th Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Priscilla Brooks Jackson</u>		4. DATE OF DEATH <u>October 12 1960</u>	
5. SEX <u>F</u>	6. COLOR OF RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 22, 1898</u>
9. AGE (in years last birthday) <u>62 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles Brooks</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Leona Isbury (daughter)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Congestive Heart Failure, Acute</u> DUE TO (b) <u>Myocardial Insufficiency</u> DUE TO (c) <u>Myocardial Infarction</u> Sudden Sudden Sudden PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>205 AM</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschaw</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschaw</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bru-Transit 10/12/60</u>		22b. DATE THEREOF <u>10/12/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Norfolk, Virginia</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>OCT 13 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kane</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1000. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

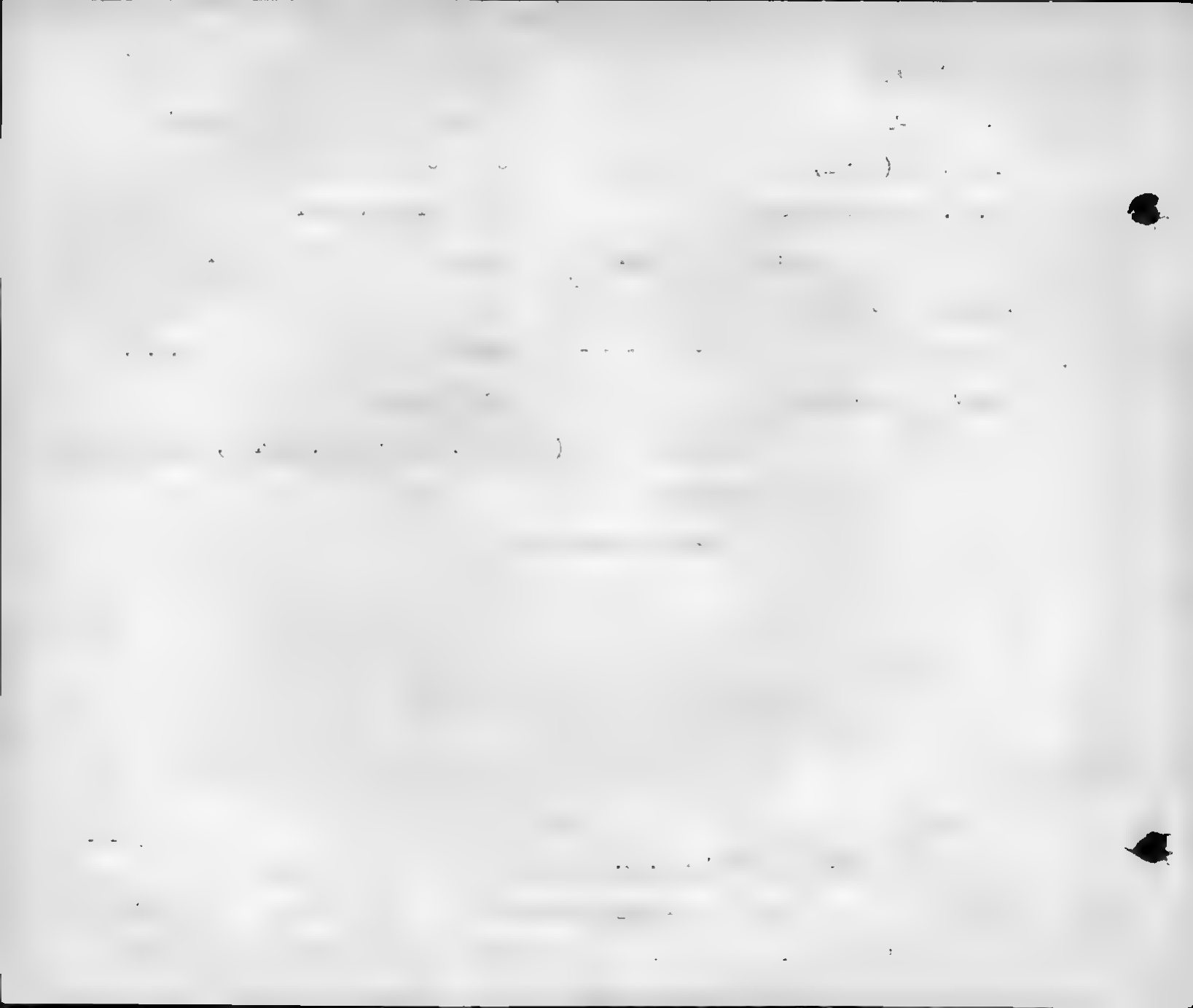
11616

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11564

<p>1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b DOA d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital</p>				<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chevy Chase d. STREET ADDRESS 3212 Parkview Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>			
<p>3. NAME OF DECEASED (Type or print) Richard Dana JOHNSON</p>		<p>4. DATE OF DEATH Month October Day 3 Year 1960</p>		<p>5. SEX Male 6. COLOR OR RACE Caucasian 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>			
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None</p>		<p>10b. KIND OF BUSINESS OR INDUSTRY None</p>		<p>8. DATE OF BIRTH 2-1-50 9. AGE (In years) 10 yrs. IF UNDER 1 YEAR: Months 10 Days 10 Hours 10 Min. 10</p>			
<p>11. BIRTHPLACE (State or foreign country) Hawaii</p>		<p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p>					
<p>13. FATHER'S NAME Robert Wayne JOHNSON</p>			<p>14. MOTHER'S MAIDEN NAME Marcy AYLWARD</p>				
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No</p>		<p>16. SOCIAL SECURITY NO. None</p>		<p>17. INFORMANT (S-F) Cdr. Roderick L. Harris, USCG, same as #2</p>			
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO (b) Acute bronchial asthma DUE TO (c) 241X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</p>				<p>INTERVAL BETWEEN ONSET AND DEATH</p>			
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e.g., 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>							
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>					
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.</p>		<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>			
<p>20f. (City or town) (County) (State)</p>		<p>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p>					
<p>ACTUAL SIGNATURE Frank J. Broeschart EXAMINER'S NAME (Type) Frank Broeschart, M. D.</p>		<p>CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></p>		<p>DATE SIGNED 10-3-60</p>			
<p>22a. BURIAL, CREMATION, REMOVAL (Specify) Burial</p>		<p>22b. DATE THEREOF 10-7-60</p>		<p>22c. NAME OF CEMETERY OR CREMATORY Arlington National</p>			
<p>22d. LOCATION (City, town, or country) Arlington</p>		<p>(State) Virginia</p>					
<p>23. FUNERAL DIRECTOR Jos. Gawler's & Sons, 1756 Penn. Ave., NW, WashDC</p>		<p>24a. REC'D BY REGISTRAR OCT 5 '60</p>		<p>24b. REGISTRAR'S SIGNATURE Arthur L. Kraus</p>			

MEDICAL CERTIFICATION



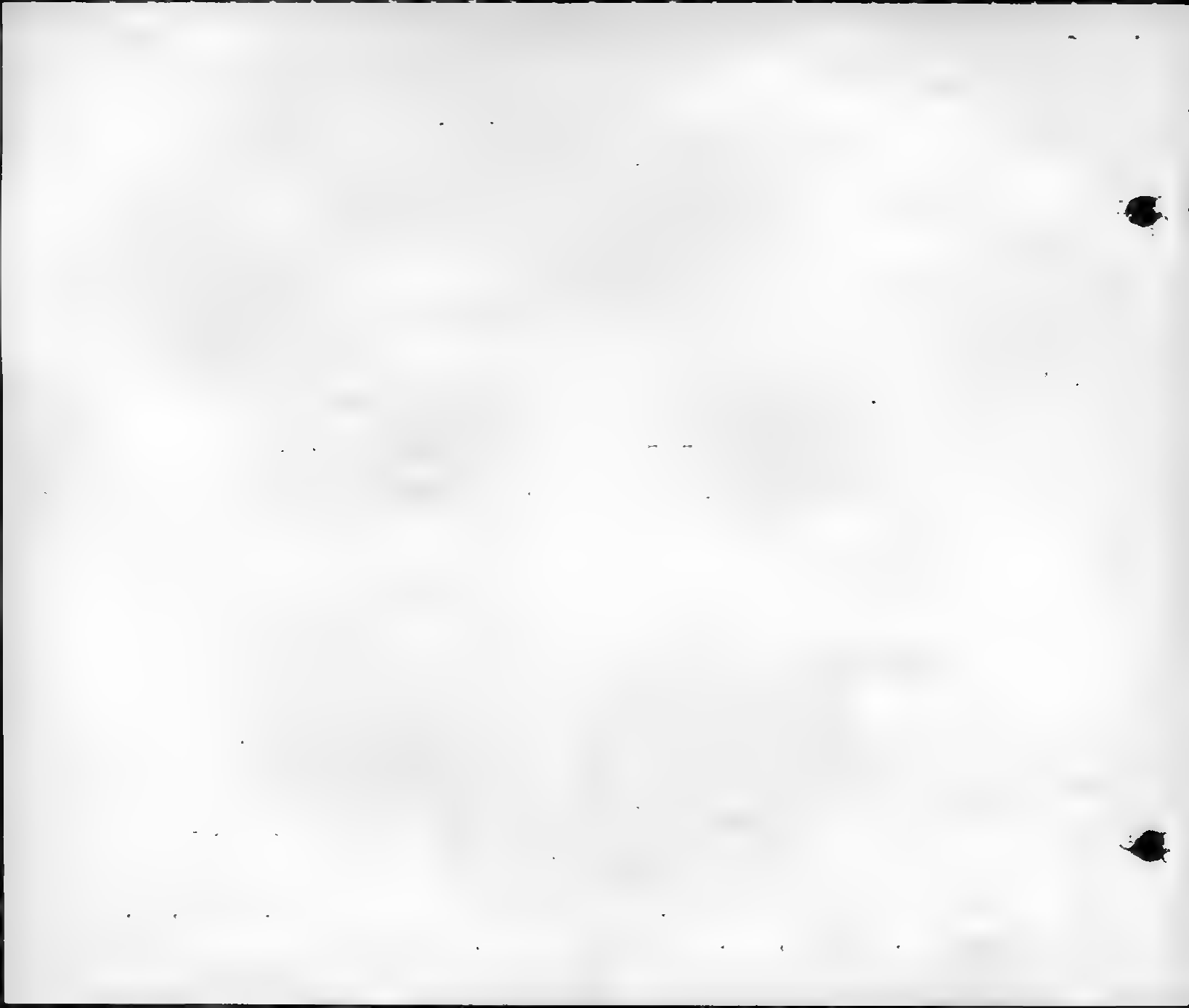
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11532

11565

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>12 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		22 <u>22</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>9411 Biltmore Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>Lewis</u> Last <u>Keane</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>8</u> Year <u>1960</u>			
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/26/05</u>		9 AGE (In years last birthday) <u>54</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Model maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NCL</u>		11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John R. Keane</u>				14 MOTHER'S MAIDEN NAME <u>Ella Dent</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>577-03-3464</u>		17 INFORMANT <u>Hospital Records</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastro-intestinal bleeding</u> <u>5.6 I.C.</u> DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Embolism of liver</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>13 days</u> <u>years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c TIME OF INJURY Month, Day Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u>	
21 I certify that (I) (this hospital) attended the deceased from <u>9-26</u> <u>1960</u> to <u>10-8</u> <u>1960</u> , that (I) last saw the deceased alive on <u>10-8</u> <u>1960</u> , and that death occurred at <u>5:30</u> PM, from the causes and on the date stated above.							
22a SIGNATURE <u>Dwight R. Smith</u> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED <u>10-8-60</u>	
22c PHYSICIAN'S NAME (Type) <u>DWIGHT R. SMITH, M.D.</u> <u>1015 SPRING ST. SIL. SPR. MD.</u>				22d ADDRESS <u>1015 SPRING ST</u> <u>SIL. SPR. MD.</u> <u>24-9-3310</u>			
23a BURIAL, CREMAT OR REMOVAL (Specify) <u>BURIAL</u>		23b DATE THEREOF <u>10/11/60</u>		23c NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>		23d LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>WERNER E. PUMPHREY, INC.</u> <u>Raymond A. Jaska</u>				ADDRESS <u>SILVER SPRING, MD.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 13 '60</u>	
				25b REGISTRAR'S SIGNATURE <u>Charles E. King</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

11617

11566

1

11617

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>2 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>Box # 1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Infant</u> Middle <u>Girl</u> Last <u>Keith</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>21</u> Year <u>19 60</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/21/60</u>			
9. AGE (In years last birthday) <u>2</u> yrs		IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min <u>-</u>		IF UNDER 24 HRS. Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min <u>-</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME <u>Arthur Moore</u>					
14. MOTHER'S MARDEN NAME <u>Alberta Elizabeth Keith</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)					
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Alberta Elizabeth Keith</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>776X</u> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.									
22a. SIGNATURE <u>[Signature]</u> M.D.				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/21/60</u>			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>Oct 21 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Suburban Hospital</u>		23d. LOCATION (City, town, or county) <u>8600 Old Georgetown Rd. N.D.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>8600 Old Georgetown Rd. N.D.</u>				25a. REC'D BY REGISTRAR <u>[Signature]</u> DATE <u>NOV 7 '60</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be filed within 24 hours after death. If any fee is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. C. Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11618 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11567

1. PLACE OF DEATH e. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Clarksburg</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Clarksburg (rural)</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Stringtown Rd - (rural)</u>		d. STREET ADDRESS <u>Stringtown Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Carl W. King</u>		4. DATE OF DEATH <u>Oct 23 1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-28-1895</u>
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired <u>Carpenter</u>		9. AGE (in years last birthday) <u>65</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS: Hours <u>0</u> Min. <u>0</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>md</u>	
13. FATHER'S NAME <u>John B King</u>		14. MOTHER'S MAIDEN NAME <u>Luriana Burns</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes W.V. # 1</u>		16. SOCIAL SECURITY NO. <u>219-07-2553</u>	
17. INFORMANT <u>Walden King - Clarksburg md - R-1</u>		Address <u></u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u></u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u></u> p.m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 26, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or country) (State) <u>Ft. Myer Virginia</u>	
23. FUNERAL DIRECTOR <u>Charles L. Molsworth</u>		24a. REC'D BY REG. STRAR <u>OCT 26 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>		DATE <u></u>	

INTERVAL BETWEEN ONSET AND DEATH
Found dead on floor at home



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

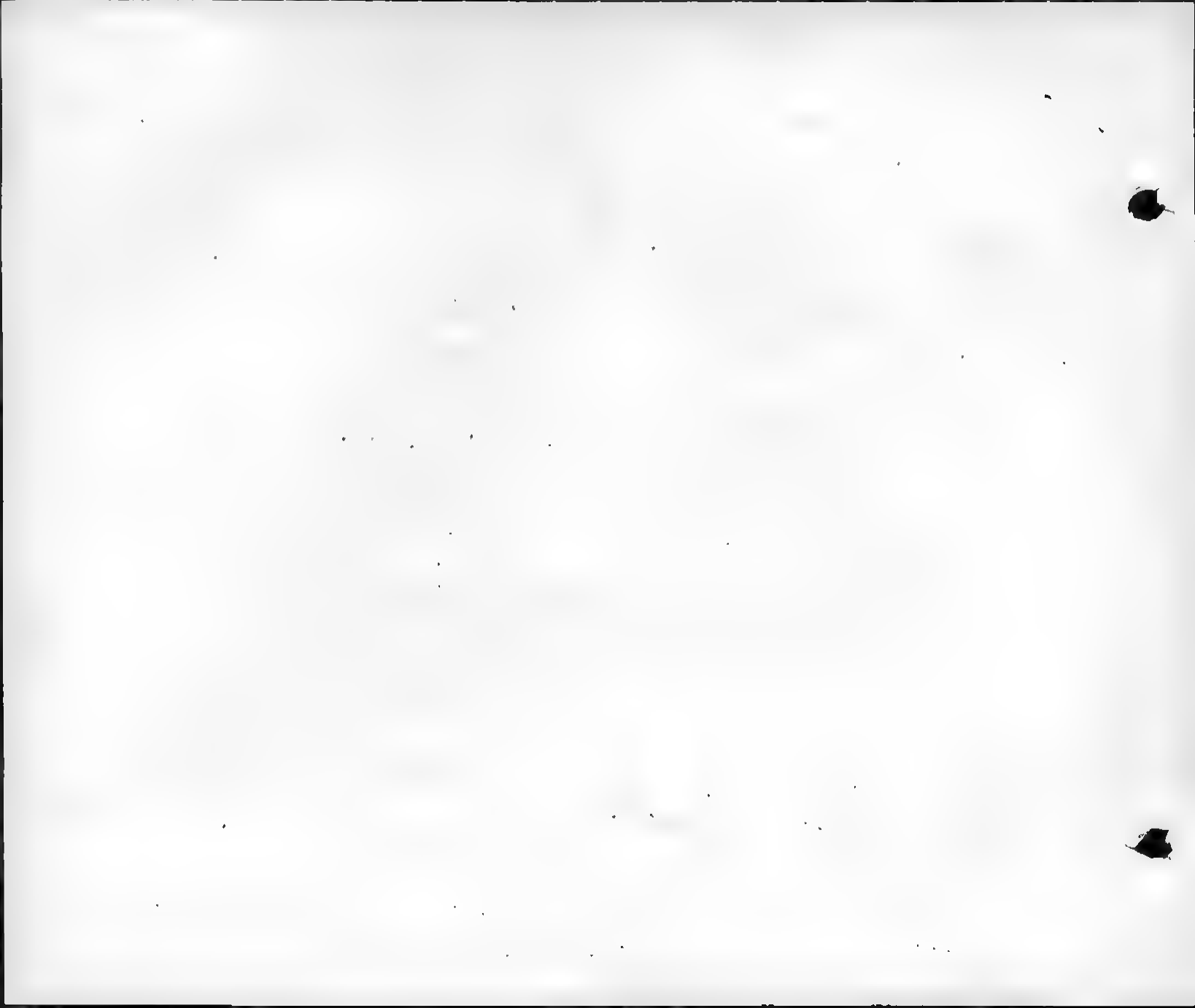
11619 CERTIFICATE OF DEATH

11568

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Boyd c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 153				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admision) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Boyd d. STREET ADDRESS Box 153 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JOHN OLIVER KNOTT First Middle Last			4. DATE OF DEATH Month Oct. Day 5 Year 1960				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 2/27/1888		9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months 7 Days 8 Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		
12. CITIZEN OF WHAT COUNTRY? X US			13. FATHER'S NAME Unknown				
14. MOTHER'S MAIDEN NAME Unknown			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				
16. SOCIAL SECURITY NO. 212-16-2702		INFORMANT Address John G. Knott-Son-same 2d					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 502.1 Cox Pulmonale, Acute + Chronic DUE TO chronic Pulmonary Fibrosis + Emphysema (b) chronic Bronchitis DUE TO 10 years (c) 11 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Aortic aneurysm							
19. INTERVAL BETWEEN ONSET AND DEATH 5 years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 31 May, 1951 to 5 October, 1960 that I last saw the deceased alive on 5 October, 1960 and that death occurred at 4:10 AM from the causes and on the date stated above. ACTUAL SIGNATURE Gordon M Smith M.D. Barnesville, Md DATE SIGNED 5 Oct 60 PHYSICIAN'S NAME (Type) Gordon M Smith Barnesville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/7/60		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery			
22d. LOCATION (City, town, or county) Rockville, Maryland		23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Robert A. Pumphrey Bethesda, Maryland					
24a. REC'D BY REGISTRAR DATE OCT 7 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline					

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

VS. A15ME
5M 7/59

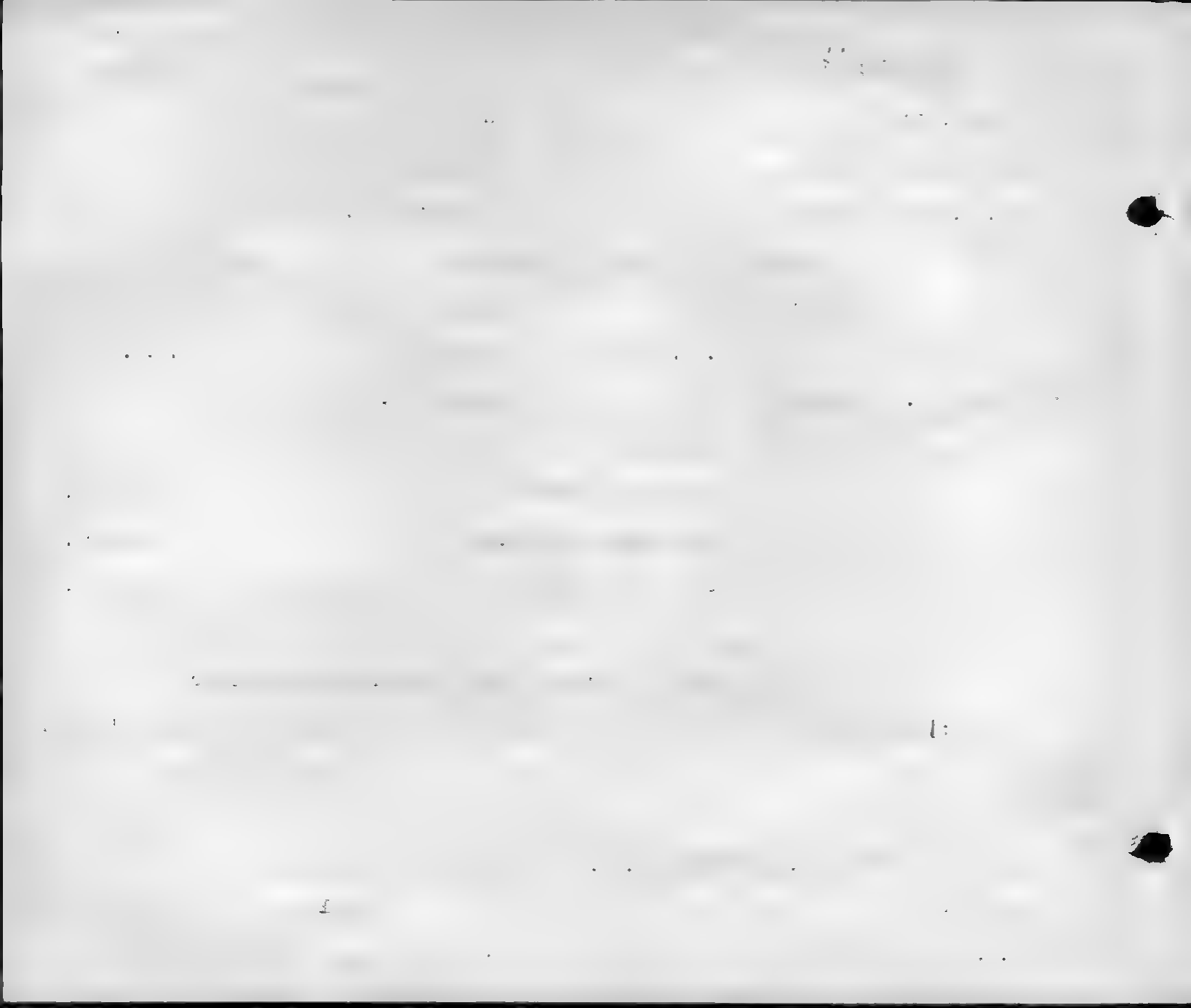
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

11620 **MARYLAND STATE DEPARTMENT OF HEALTH**
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11569

1. PLACE OF DEATH a. COUNTY Montgomery			2. USUAL RESIDENCE (Where deceased lived. If institution, list before admission) a. STATE Indiana b. COUNTY Indianapolis		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY in 1b 14 hrs.		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital					
3. NAME OF DECEASED (Type or print) Thomas Allen LAVENGOD			4. DATE OF DEATH Month October Day 30 Year 1960		
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-29-37	9. AGE (In years last birthday) 23 yrs.	10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) Indiana	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Lorin B. LAVENGOD			14. MOTHER'S MAIDEN NAME Genevieve R.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war/dates of service) Yes 1957 to DOD			16. SOCIAL SECURITY NO. 305-36-0088		
17. INFORMANT Hospital Records			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial hemorrhage DUE TO (b) Multiple skull fractures DUE TO (c) Automobile accident					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Passenger in car which left road and struck culvert					
20c. TIME OF INJURY Month, Day, Year 11:10PM 10-29-60		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street-Willows Rd Lexington Pk, St. Mary's, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Frank J. Broschart			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) Frank J. BROSCART, M. D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment			22b. DATE THEREOF 11-1-60		
22c. NAME OF CEMETERY OR CREMATORY Whitney			22d. LOCATION (City, town, or country) (State) Kentucky		
23. FUNERAL DIRECTOR W.W. Chambers Funeral Home, 1400 Chapin St. N.W.			24a. REC'D BY REGISTRAR DATE 11/31/60		
			24b. REGISTRAR'S SIGNATURE Arthur S. Evans		

NOV 2 '60



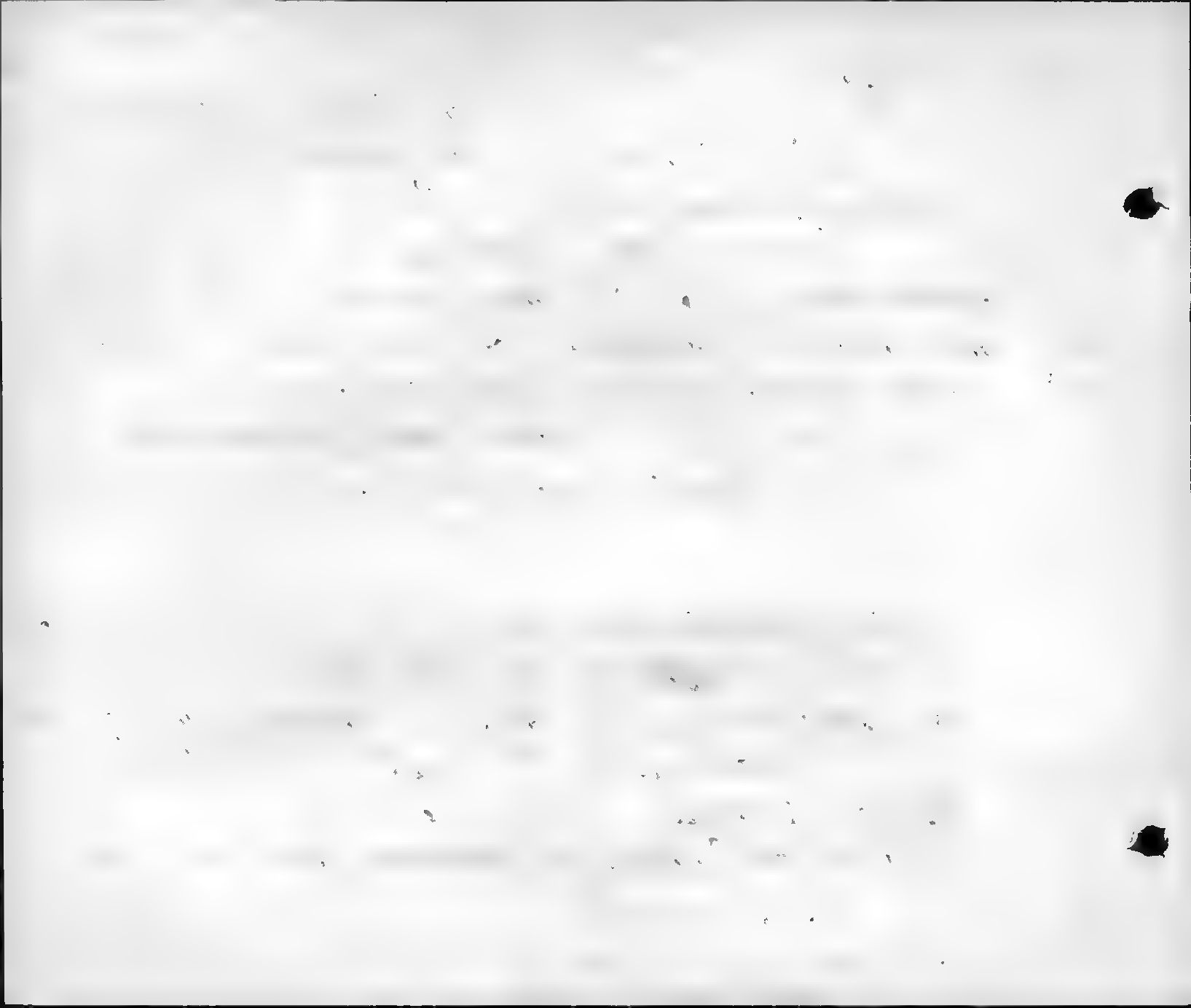
ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO HOSPITAL: may be used by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This page should be removed from the carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11621

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

11570

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Potomac</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Hickerson</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Partnership Nursing Home</i>				d. STREET ADDRESS <i>Route 1</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Leona</i> Middle <i>May</i> Last <i>Smithcum</i>				4. DATE OF DEATH Month <i>Oct.</i> Day <i>9</i> Year <i>1960</i>			
5. SEX <i>female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>March 20, 1885</i>	
9. AGE (In years last birthday) <i>75</i> yrs		10. IF UNDER 1 YEAR Months <i>6</i> Days <i>19</i>		11. IF UNDER 24 HRS Hours <i></i> Min <i></i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>home-keeping</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>		11. BIRTHPLACE (State or foreign country) <i>Hickerson, Md</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>John Wallace Cairns</i>				14. MOTHER'S MAIDEN NAME <i>Harnet A. Hays</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>				16. SOCIAL SECURITY NO. <i></i>		17. INFORMANT <i>Eleanor L. White, Hickerson, Md. R-1</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>fractured left femur</i> <i>703.0</i> DUE TO (b) <i></i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <i></i>				INTERVAL BETWEEN ONSET AND DEATH <i>32 days</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) <i>arteriosclerotic dementia</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>Tipped on rug in her home</i>			
20c. TIME OF INJURY Month <i>Sep-7</i> Day <i>1960</i> Year <i>8</i> o. m. <i></i> p. m. <i></i>				20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input checked="" type="checkbox"/> of work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	
20f. (City or town) <i>Hickerson, Montg-Md</i> (County) <i></i> (State) <i></i>							
21. I certify that (I) (this hospital) attended the deceased from <i>Sept-2-1960</i> to <i>Oct-9-1960</i> , that (I) (we) last saw the deceased alive on <i>Oct-8-1960</i> , and that death occurred at <i>6AM</i> , from the causes and on the date stated above.							
22a. SIGNATURE <i>William C. Miller</i>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <i></i>	
22c. PHYSICIAN'S NAME (Type) <i>WILLIAM C. MILLER</i>				22d. ADDRESS <i>7 Brooke Ave., Gaithersburg, Md.</i>			
23a. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Oct. 11, 1960</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Monocacy Cemetery</i>		23d. LOCATION (City, town or county) <i>Beallsville</i> (State) <i>Maryland</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>M. R. Etchison & Son, Frederick, Maryland</i>				25a. REC'D BY REGISTRAR <i>Oct 11 1960</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hays</i>	



TO HOSPITAL: This certificate may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11622

11571

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 158 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS Rt. #1, Box 133-C			
3. NAME OF DECEASED (Type or print) First Harry Middle Last LOMBARD				4. DATE OF DEATH Month October Day 21 Year 19 60			
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-18-92		9. AGE (In years last birthday) 68 yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) Oregon		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James LOMBARD				14. MOTHER'S MAIDEN NAME Sarah BOWSER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WWI		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the lung - metastatic 163 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 16 19 60 to Oct. 21 19 60 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Oct. 21 19 60 and that death occurred at 8:55AM from the causes and on the date stated above							
22a. SIGNATURE R. C. THOMAS, LT, MC, USN				22b. DATE SIGNED 10-21-60			
22c. PHYSICIAN'S NAME (Type) R. C. THOMAS, LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment		23b. DATE THEREOF 10-22-60		23c. NAME OF CEMETERY OR CREMATORY Bethany Cemetery		23d. LOCATION (City, town, or county) (State) Charleston, South Carolina	
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home, 4th & Mass. Aves., N.E., WashDC				25a. REC'D BY REGISTRAR OCT 27 1960		25b. REGISTRAR'S SIGNATURE Arthur S. Frank	



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 2

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

11623

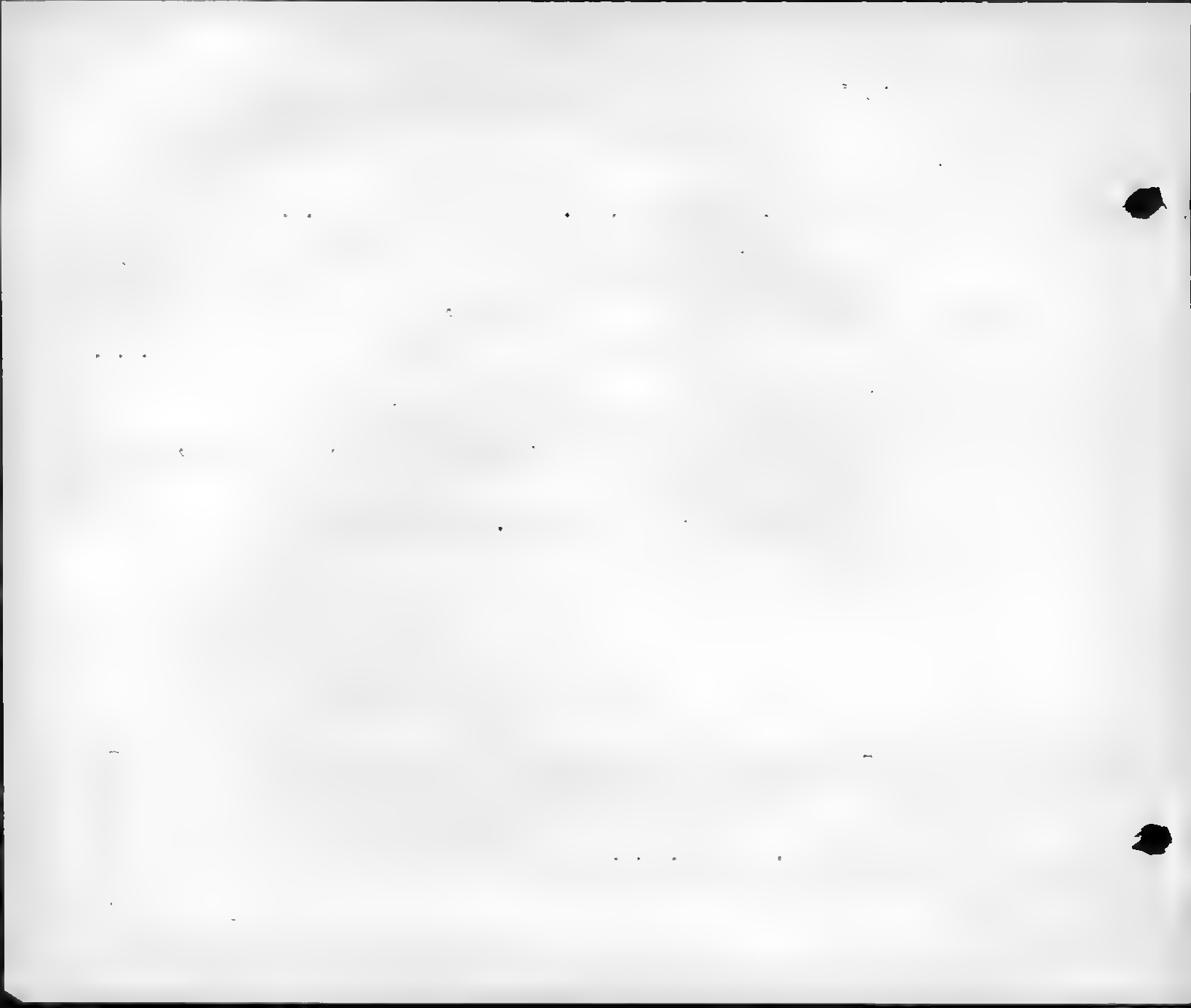
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11572

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 51 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 212 37th Place, S.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Flossie Middle Thelma Last Lott		4. DATE OF DEATH Month October Day 19 Year 1960	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 13, 1908
9. AGE (In years last birthday) 52 yrs		10. IF UNDER 1 YEAR Months 52 Days 19 Hours 19 Min 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Household	
11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Preston Griffin		14. MOTHER'S MAIDEN NAME Lishia Ross	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO. Unavailable	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Uremic coma DUE TO Arteriolar nephrosclerosis & Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriolar nephrosclerosis & Hypertension (c) Arteriolar nephrosclerosis & Hypertension PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriolar nephrosclerosis & Hypertension INTERVAL BETWEEN ONSET AND DEATH 50 days years 50		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (A) (this hospital) attended the deceased from August 22, 1960 to October 19, 1960 , that (H) (we) last saw the deceased alive on October 19, 1960 , and that death occurred at 4:15 PM from the causes and on the date stated above			
22a. SIGNATURE Thomas C. Morigan		22b. DATE SIGNED 10/20/60	
22c. PHYSICIAN'S NAME (Type) Thomas C. Morigan, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Oct. 22, 1960		23b. DATE THEREOF Oct. 22, 1960	
23c. NAME OF CEMETERY OR CREMATORY Brundage		23d. LOCATION (City, town, or county) (State) Ula	
24. FUNERAL DIRECTOR'S SIGNATURE Theresa Hume		25a. REC'D BY REGISTRAR DC DATE OCT 24 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Hume		25c. REGISTRAR'S SIGNATURE Arthur S. Hume	

1

2



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT.

M

I

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 9502 SAYBROOK DRIVE									
2. USUAL RESIDENCE (Where deceased lived, if not permanent residence, give address before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE'S c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) OXEN HILL d. STREET ADDRESS 6671 HOLLY DRIVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First JOHN Middle R Last LUCK, Jr. 4. DATE OF DEATH OCT. 11 19 60 Month Day Year									
5. SEX MALE 6. COLOR OR RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 12/28/12 9. AGE (In years last birthday) 47 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TECHNICAL WRITER 10b. KIND OF BUSINESS OR INDUSTRY VITRO CORP. 11. BIRTHPLACE (State or foreign country) BOSTON, MASS. 12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME JOHN R. LUCK, SR. 14. MOTHER'S MAIDEN NAME WANDA unknown									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes WW # 2 16. SOCIAL SECURITY NO. WW # 2 17. INFORMANT Mrs. Nancy L. Delozier, 6671 Holly Dr., S.E. Oxen Hill, Md. Address									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO (b) Fatal death in chair at home DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 60 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Oct 11 - 1960 Address (Street, city, town, or county)									
ACTUAL SIGNATURE Frank J. Broschart M.D. EXAMINER'S NAME (Type) FRANK J. BROSCHELT DATE SIGNED Oct 11 - 1960									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF Oct 14 - 60 22c. NAME OF CEMETERY OR CREMATORY Arlington National 22d. LOCATION (City, town, or country) (State) Arlington VA									
23. FUNERAL DIRECTOR Seniors Bros 1661 - 9th Hope Rd S E ADDRESS Wash DC 24a. REC'D BY REGISTRAR OCT 13 '60 24b. REGISTRAR'S SIGNATURE Arthur S. Hunt									

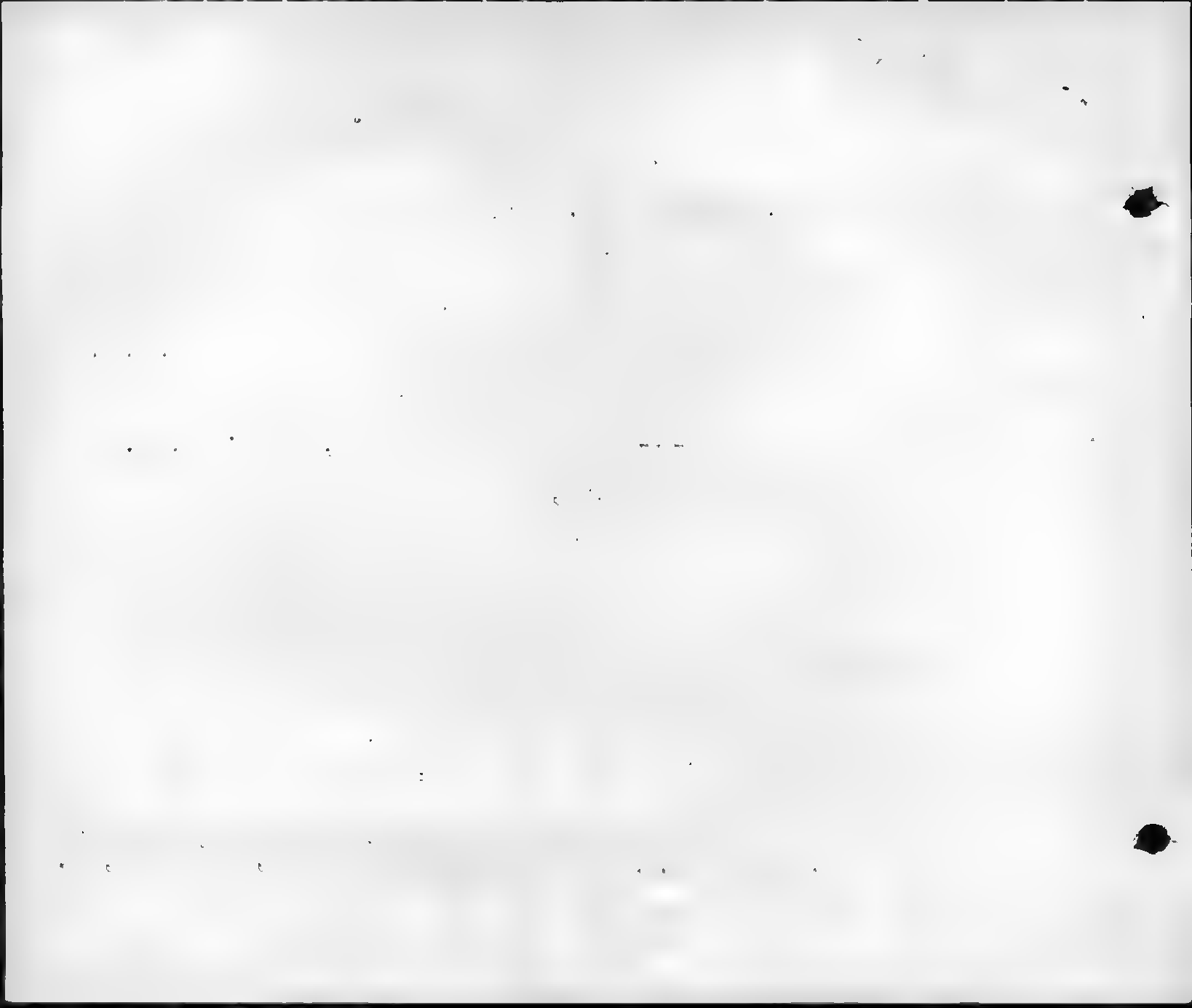


CERTIFICATE OF DEATH

11574

11624

1. PLACE OF DEATH a. COUNTY Montgomery	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE Pennsylvania		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Bethesda	c. LENGTH OF STAY IN 1b 73 days	c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Chester	d. STREET ADDRESS 911 Lincoln Street	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.	4. DATE OF DEATH Month October Day 16 Year 19 60	5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 24, 1939
9. AGE (in years last birthday) 21 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder	10b. KIND OF BUSINESS OR INDUSTRY Private	11. BIRTHPLACE (State or foreign country) Tennessee	12. CITIZEN OF WHAT COUNTRY? U. S. A.	13. FATHER'S NAME Bruce Maines
14. MOTHER'S MAIDEN NAME Anne Taylor	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 167-30-4889	17. INFORMANT The Medical Record	Address The Clinical Center, Bethesda 14, Md.	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary embolus, right pulmonary artery DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Adrenocortical carcinoma DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____	19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	20c. TIME OF INJURY Hour _____ a m _____ p m Month _____ Day _____ Year _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____	21. I certify that (I) (this hospital) attended the deceased from August 16, 1960 to October 16, 1960 that (I) (we) last saw the deceased alive on October 16, 1960 and that death occurred 10:30 am from the causes and on the date stated above.	22a. SIGNATURE <i>Leo L. Stolbach</i> M. D.	22b. DATE SIGNED 10/16/60	22c. PHYSICIAN'S NAME (Type) LEO L. STOLBACH, M.D.
22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/20/60	23c. NAME OF CEMETERY OR CREMATORY Lawn Croft Cemetery	23d. LOCATION (City, town, or county) (State) Linwood, Penna.	24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE OCT 21 '60	25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hirsch</i>				



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11535 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11575

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY in 1b <u>5da. 9 1/2 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San and Hosp</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Monrovia</u> d. STREET ADDRESS <u>R.F. J.</u>			
3. NAME OF DECEASED (Type or print) <u>Larry David Mann</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>26</u> Year <u>1960</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 16, 1944</u> 16 yrs.		9. AGE (in years last birthday) <u>16</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Helper-Contractor Carpenter-Contr.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
13. FATHER'S NAME <u>Garland Mann</u>		14. MOTHER'S MARRIED NAME <u>Hilda Fawley</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-40-2601</u>		17. INFORMANT <u>Record</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral edema</u> DUE TO (b) <u>Massive epidural hemorrhage (left)</u> DUE TO (c) <u>Fracture of skull</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH <u>5 1/2 days</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fall from ladder and struck head on concrete block</u>					
20c. TIME OF INJURY Month, Day, Year <u>2:00 p.m. 10-20 1960</u>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, office, etc.) <u>Self Storage</u>			
20f. (City or town) <u>Montg.</u>		20g. (County) <u>Montg.</u>		20h. (State) <u>md</u>			
21. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Brossant</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Brossant</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>10-26-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 28, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Damascus Meth.</u>			
22d. LOCATION (City, town, or country) <u>Damascus Md.</u>		22e. ADDRESS <u>Damascus, Md.</u>		22f. REC'D BY REGISTRAR <u>Oct 28 '60</u>			
22g. REGISTRAR'S SIGNATURE <u>Olin L. Mohrman</u>		22h. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>					



TO HOSPITAL: The attending physician: The IOM requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and must be completed within 72 hours after death.

4 1 4
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
11625
11576
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b 23 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN Hospital				d. STREET ADDRESS 105 Wall St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last THELBERT ASHLEY MANNING				4. DATE OF DEATH October 22 1960			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/23/02	
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Engineering		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME MANNING				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No		16. SOCIAL SECURITY NO Yes-Unknown		17. INFORMANT Address Lavinia D. Manning-wife-same 2d			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA OF HEAD OF PANCREAS (METASTASES) 14 MONTHS 157X DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from AUG 15, 1960 to OCT. 22, 1960, that (I) (we) last saw the deceased alive on OCT. 22, 1960, and that death occurred at 4:55 PM, from the causes and on the date stated above.							
22a. SIGNATURE John N. Tuohy M.D.		22b. ADDRESS 7720 WISLONGIN AVE BETHESDA 14, MD.		22c. PHYSICIAN'S NAME (Type) JOHN H. TUOHY, M.D.		22d. DATE SIGNED 10/22/60	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 10-23-60		23c. NAME OF CEMETERY OR CREMATORY HYDEN CEMETERY		23d. LOCATION (City, town, or county) (State) HYDEN NORTH CAROLINA	
24. FUNERAL DIRECTOR'S SIGNATURE Robert H. Humphrey, 7557 Wise Ave. Beth. Md.				25a. REC'D BY REGISTRAR DATE OCT 25 '60		25b. REGISTRAR'S SIGNATURE Christ S. Kiana	

CARCINOMA OF HEAD OF PAN

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
11626 11577											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest Glen</u> c. LENGTH OF STAY IN <u>5 min.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Walter Reed Annex</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Va</u> b. COUNTY <u>Stafford Court House</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>R-1 Box 451</u> d. STREET ADDRESS <u>Oct 25 1960</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF <u>Harlan E. Matter</u> (Type or print) First Middle Last						4. DATE OF DEATH <u>Oct 25 1960</u> Month Day Year					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-23-23</u>		9. AGE (In years last birthday) <u>37</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Major M-S. Army</u>						10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>S. D.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>August M. Matter</u>						14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>U.S. Army - Records</u>						16. SOCIAL SECURITY NO. <u>U.S. Army - Records</u>					
17. INFORMANT <u>U.S. Army - Records</u>						Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>430.1</u> IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>10-25-60</u>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Oct. 31, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FORT SAM HEUSTON NATIONAL</u>		22d. LOCATION (City, town, or country) (State) <u>SAN ANTONIO TEXAS</u>					
23. FUNERAL DIRECTOR <u>Funeral Home 816 N. H. N. E. DC 2</u>						24a. REC'D BY REGISTRAR <u>OCT 28 '60</u>		24b. REGISTRAR'S SIGNATURE <u>C. L. H. H. H.</u>			



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> 11627 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND 11578 </div>											
1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Norbeck</u> c. LENGTH OF STAY IN 1b <u>months</u>				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jakoma Park</u> d. STREET ADDRESS <u>1114 Park Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3 NAME OF DECEASED (Type or print) First <u>WINIFRED</u> Middle <u>G.</u> Last <u>MATTIMORE</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>6</u> Year <u>1960</u>				5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>November 13, 1876</u> 9. AGE (In years last birthday) <u>83</u> 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> 11. IF UNDER 24 HRS Hours <u> </u> Min <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Alterations Clerk (Retired)</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Department Store</u> 11. BIRTHPLACE (State or foreign country) <u>Nashville, Tennessee</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>John Mattimore</u> 14. MOTHER'S MAIDEN NAME <u>Catherine Kelly</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) <u>No</u> 16. SOCIAL SECURITY NO <u>412 14 4629A</u> 17. INFORMANT <u>Mrs. Mary E. Rea (Dame as #2)</u> Address <u> </u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO <u>10 yrs.</u> (c) <u> </u>											
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u> </u>											
20c. TIME OF INJURY Month. <u> </u> Day. <u> </u> Year <u>19</u> Hour a. m. <u> </u> p. m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>			
21. I certify that (I) (this hospital) attended the deceased from <u>June 1, 1958</u> to <u>10-6-</u> 1960 that (I) (we) last saw the deceased alive on <u>10-5-1960</u> and that death occurred at <u>4:45</u> M. from the causes and on the date stated above											
22a. SIGNATURE <u>Harry J. Kicherer</u>				22b. DATE SIGNED <u> </u>				22c. PHYSICIAN'S NAME (Type) <u>Harry J. Kicherer</u>			
22d. ADDRESS <u>5527 Surrey St, Chevy Chase, Md</u>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22f. DATE <u> </u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Oct. 10, 1960</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Mt Calvary Cemetery</u> 23d. LOCATION (City, town, or county) <u>Nashville, Tennessee</u> (State) <u> </u>				24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walter, 254 Carroll St NW DC</u> 25a. REC'D BY REGISTRAR <u> </u> DATE <u>OCT 10 '60</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>							

MEDICAL CERTIFICATION

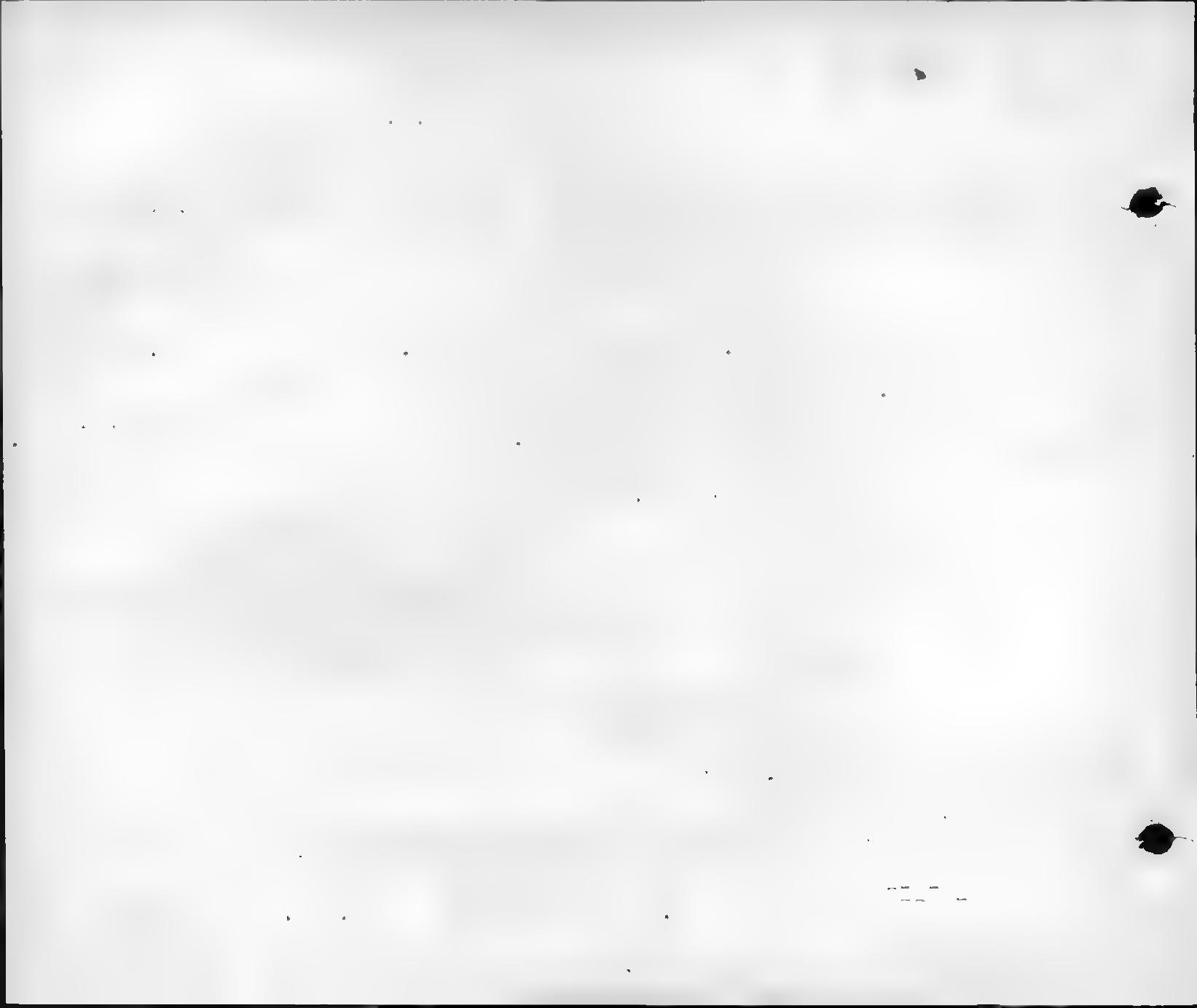


1
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11579

11554

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Nursing Home				d. STREET ADDRESS 1651 Primrose Road, N.W.			
3. NAME OF DECEASED (Type or print) First Charles Middle Harrison Last Mayers				4. DATE OF DEATH Month 10 Day 25 Year 1960			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/15/1865	
9. AGE (in years last birthday) 95 yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired, Furniture Co. Owner				10b. KIND OF BUSINESS OR INDUSTRY W. Va.		11. BIRTHPLACE (State or foreign country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George M. Mayers				14. MOTHER'S MAIDEN NAME Elizabeth Fleming			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs. Ruth Mayers Melroy				Address Wash. D.C. 1651 Primrose Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Liver DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Oct. 18, 1960 , to Oct. 25, 1960 , that (I) (we) last saw the deceased alive on Oct. 18, 1960 , and that death occurred at 10 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Harold Heites MD				22b. DATE SIGNED 10/25/60			
22c. PHYSICIAN'S NAME (Type) Harold Heites MD				22d. ADDRESS 1835 E. 57th NW Wash. DC			
23a. BURIAL, CREMATION, or other disposition 10/28/60				23b. DATE THEREOF			
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery				23d. LOCATION (City, town, or county) (State) Pr. Geo. Co., Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE The S.A. Harris Co.				25a. REC'D BY REGISTRAR 2901-14 S.W.			
25b. REGISTRAR'S SIGNATURE Arthur S. Harris				25c. DATE OCT 26 '60			



11628

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

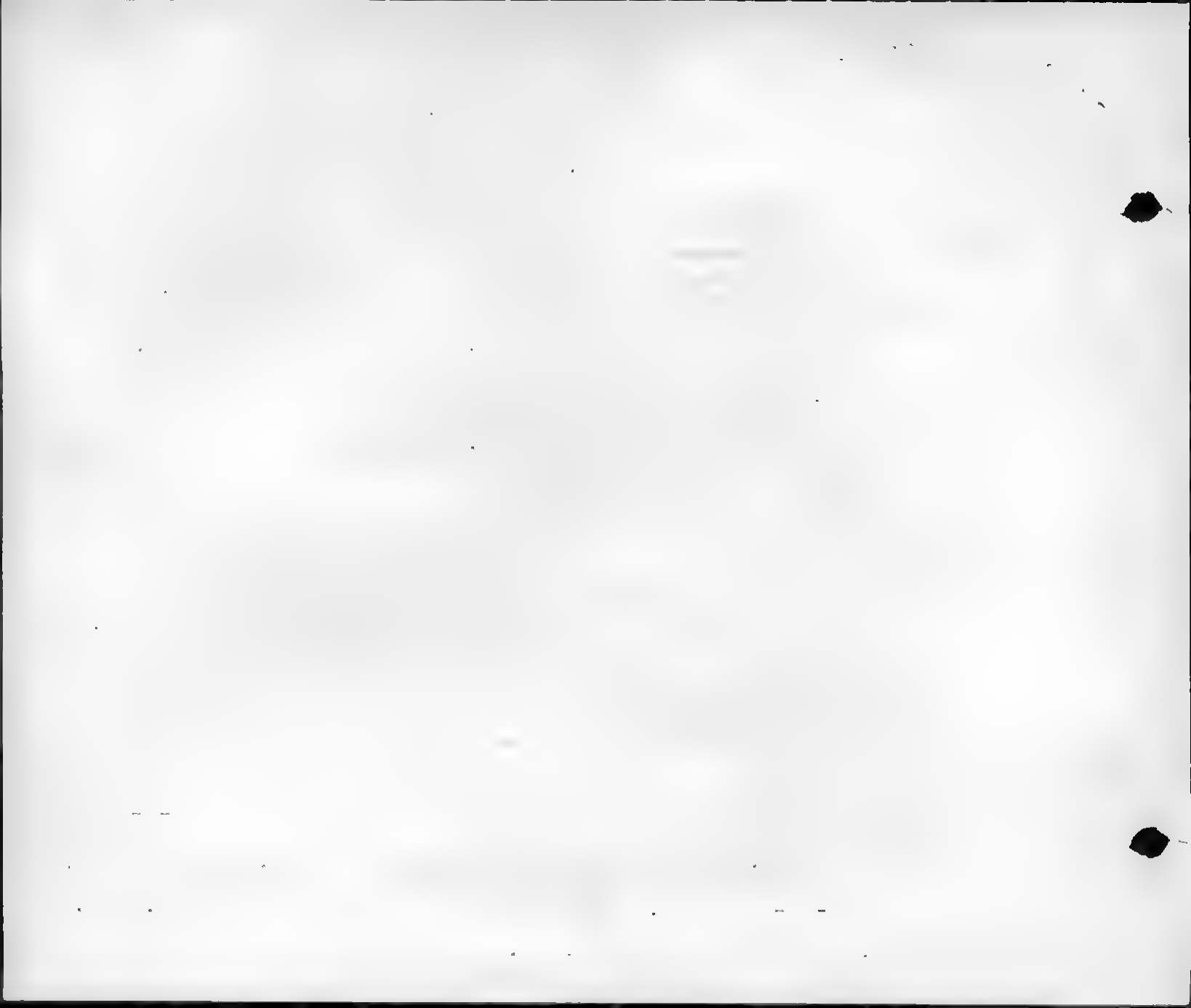
11580

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 31 1/2 hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) (Mary Ruth) Baby Girl		4. DATE OF DEATH Month 10 Day 7 Year 1960	
5 SEX Female	6 COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 10-6-60
9 AGE (In years last birthday) 12		IF UNDER 1 YEAR Months 12 Days 12	IF UNDER 24 HRS Hours 12 Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country) Maryland
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Jack W. McBride	
14. MOTHER'S MAIDEN NAME Ruth Ann Grey		15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO		17 INFORMANT Father Address Jack W. McBride Same as Item #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracerebral hemorrhage DUE TO Intaventricular hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) 34 hours (c) 36 hours		INTERVAL BETWEEN ONSET AND DEATH 34 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from Oct. 5, 1960 to Oct 7, 1960 ; that (I) (we) last saw the deceased alive on Oct 7, 1960 , and that death occurred at 9:45 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Alfred S. Norton		22b. DATE SIGNED 10-7-60	
22c. PHYSICIAN'S NAME (Type) ALFRED S. NORTON		22d. ADDRESS 4711 Highland Ave., Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-10-60	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	23d. LOCATION (City, town, or county) (State) Prince George Co., Md.
24 FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		25a. REC'D BY REGISTRAR Bethesda, Md.	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline		DATE OCT 13 '60	

2074181XV



11534

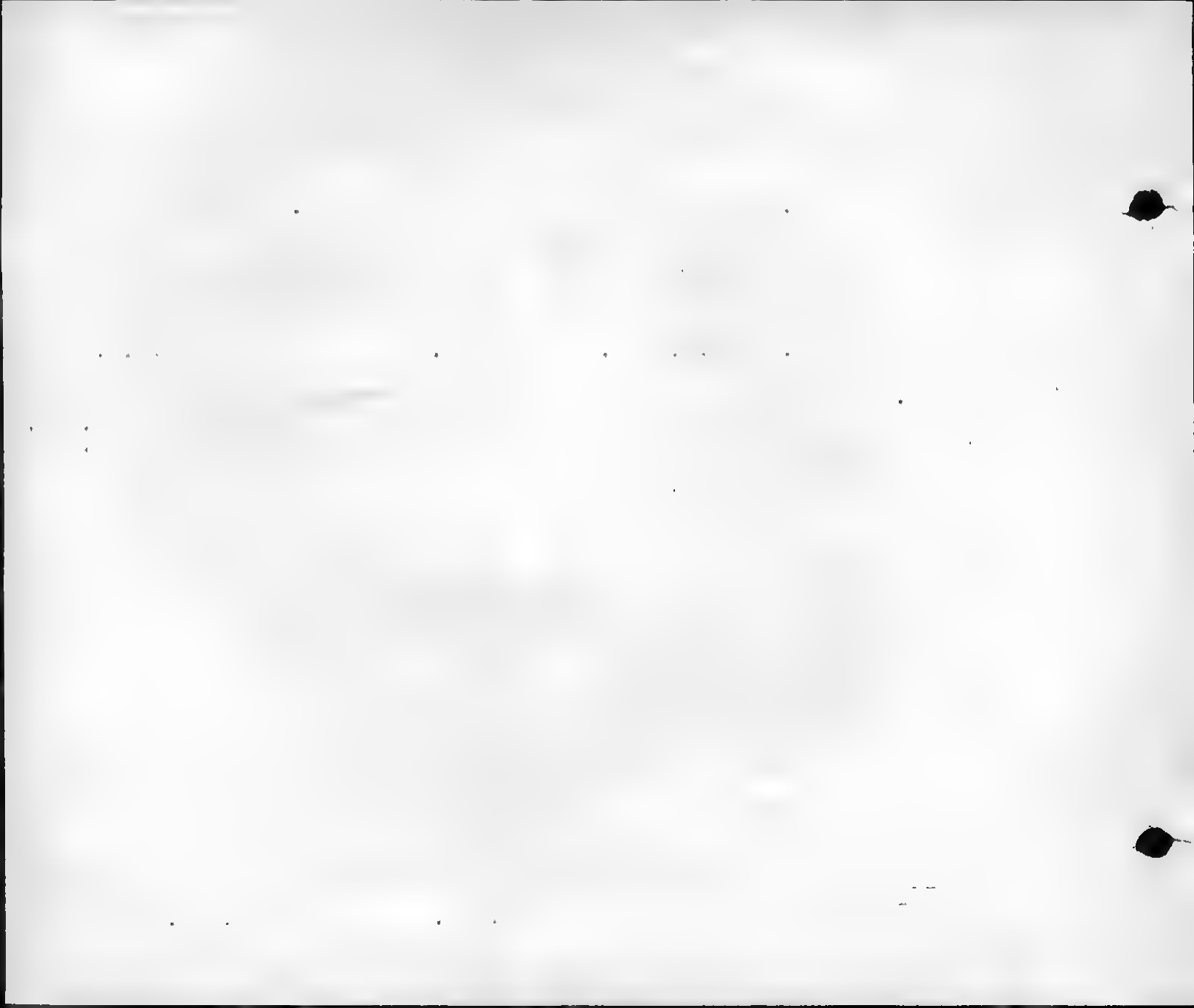
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11581

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md b. COUNTY P...			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. LENGTH OF STAY IN 1b 25 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7201 Flower Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JOHN First JOSEPH Middle McDONALD Last				4. DATE OF DEATH Oct Month 12 Day 1960 Year			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct 21, 1890	
9. AGE (in years last birthday) 69 yrs		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sanitation Dept.,				10b. KIND OF BUSINESS OR INDUSTRY D.C. Govt.		11. BIRTHPLACE (State or foreign country) Mass.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John J. McDonald				14. MOTHER'S MAIDEN NAME Ellen O'Connor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) yes (If yes, give war or dates of service) WW # 1				16. SOCIAL SECURITY NO. 7201 Flower Ave.			
17. INFORMANT Margaret McDonald				Address Takoma Pk., Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion							
DUE TO (b) Hyper tensive Heart Disease							
DUE TO (c) 2 yrs.							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 1960 to Oct 12, 1960 , that (I) last saw the deceased alive on Oct 11, 1960 , and that death occurred at 2:30 PM , from the causes and on the date stated above.							
22a. SIGNATURE Ernest A. Sarao M.D.				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) ERNEST A. SARAO M.D.				22d. ADDRESS 7006 New Hampshire Ave Takoma Park Md			
23a. BURIAL OR CREMATION REMOVAL (Specify) burial		23b. DATE THEREOF 10/14/60		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem.		23d. LOCATION (City, town, or county) (State) Arlington, Va.	
24. FUNERAL DIRECTOR'S SIGNATURE The S. H. Niven Co. 2901-14 St. NW. Wash DC				25a. REC'D BY REGISTRAR OCT 13 '60			
25b. REGISTRAR'S SIGNATURE Arthur P. H...							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

11509

11582

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LeDeau Gardens Nursing Home		d. STREET ADDRESS 110513 Montrose Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Lillian M Merrill		4. DATE OF DEATH October 26 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 1, 1876
9. AGE (In years last birthday) 84 yrs		10. IF UNDER 1 YEAR 7 Months 25 Days	
11. IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME William Payne		14. MOTHER'S MAIDEN NAME Priscilla Entwisle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. yes Unknown	
17. INFORMANT Charles M. Merrill-sog-same 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anemia, Severe DUE TO Malnutrition, hypoproteinemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic debilitation DUE TO (c) Chronic debilitation PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 24, 1960 to October 26, 1960 , that I last saw the deceased alive on October 24, 1960 , and that death occurred at 1:30 p.m. from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert T. Thibadeau M.D.		ADDRESS (Street, city or town, state) 10609 Concord Street DATE SIGNED Oct 26, 1960	
PHYSICIAN'S NAME (Type) Robert T. Thibadeau, M.D.		Kensington, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/28/60	22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery	22d. LOCATION (City, town, or county) (State) Washington, D. C.
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR DATE OCT 28 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

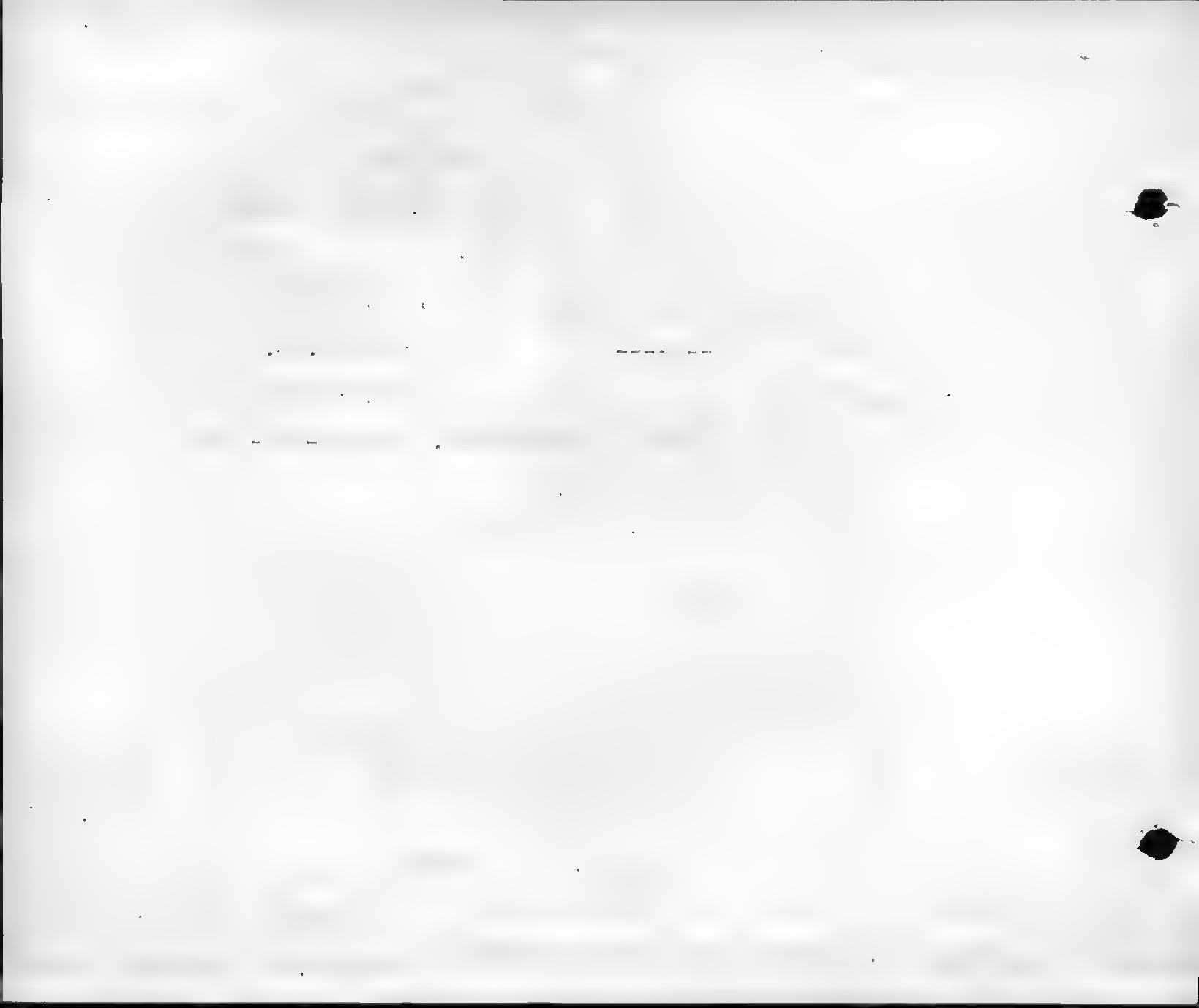
TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filled with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11535

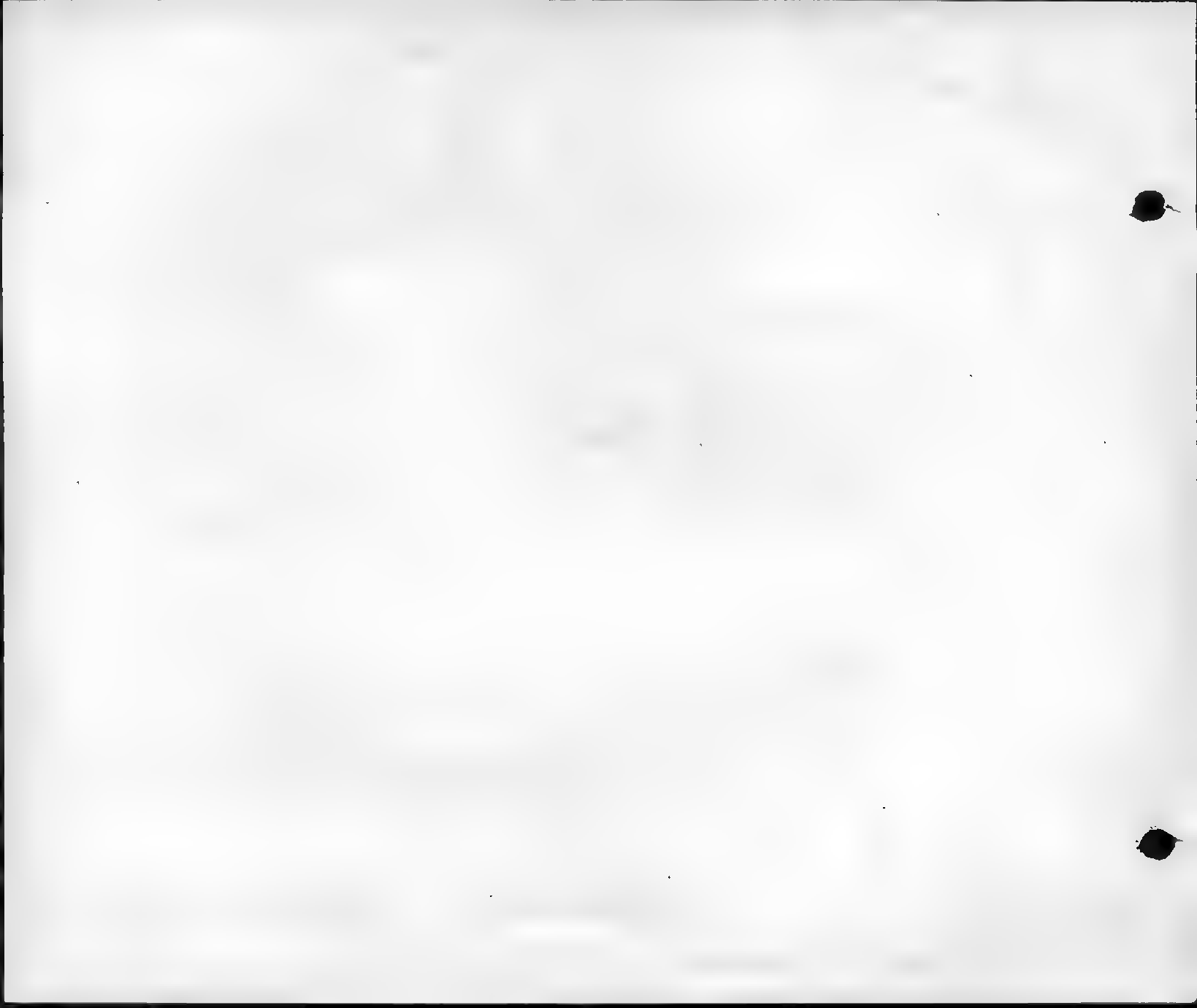
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>418 E. Franklin Ave</u>			
3. NAME OF DECEASED (Type or print) <u>Rose Lea Metter</u>				4. DATE OF DEATH <u>October 30 1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cauc.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>7-08-06</u>	
9. AGE (In years last birthday) <u>34</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Finland</u>				12. CITIZEN OF WHAT COUNTRY? <u>America</u>			
13. FATHER'S NAME <u>Abraham Metter</u>				14. MOTHER'S MAIDEN NAME <u>Vera Faenick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO <u>561-09-3160</u>			
17. INFORMANT <u>Dister - Mrs. Michael Pegab - Silver Spring, Md</u>				Address <u>418 E. Franklin Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE HEART FAILURE</u> 241X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASTHMA, PERENNIAL</u> DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Oct 24</u> , 1960, to <u>Oct 30</u> , 1960, that I last saw the deceased alive on <u>October 30</u> , 1960, and that death occurred at <u>8:20</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert L. Krichmar</u>				ADDRESS (Street, city or town, state) <u>77-33 ALASKA AVE. S.W. DIST. C.D.</u>			
PHYSICIAN'S NAME (Type) <u>ROBERT L. KRICHMAR MD</u>				DATE SIGNED <u>NOV 2 1960</u>			
22a. DATE OF REMOVAL (Specify) <u>NOV 2-1960</u>				22b. NAME OF REMOVAL OR CREMATION <u>WASH. PARK INGLEWOOD CALIF.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wesley Funeral Home</u>				ADDRESS <u>4217-9th Ave NW</u>		24a. REC'D BY REGISTRAR <u>NOV 1 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 1.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Than please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

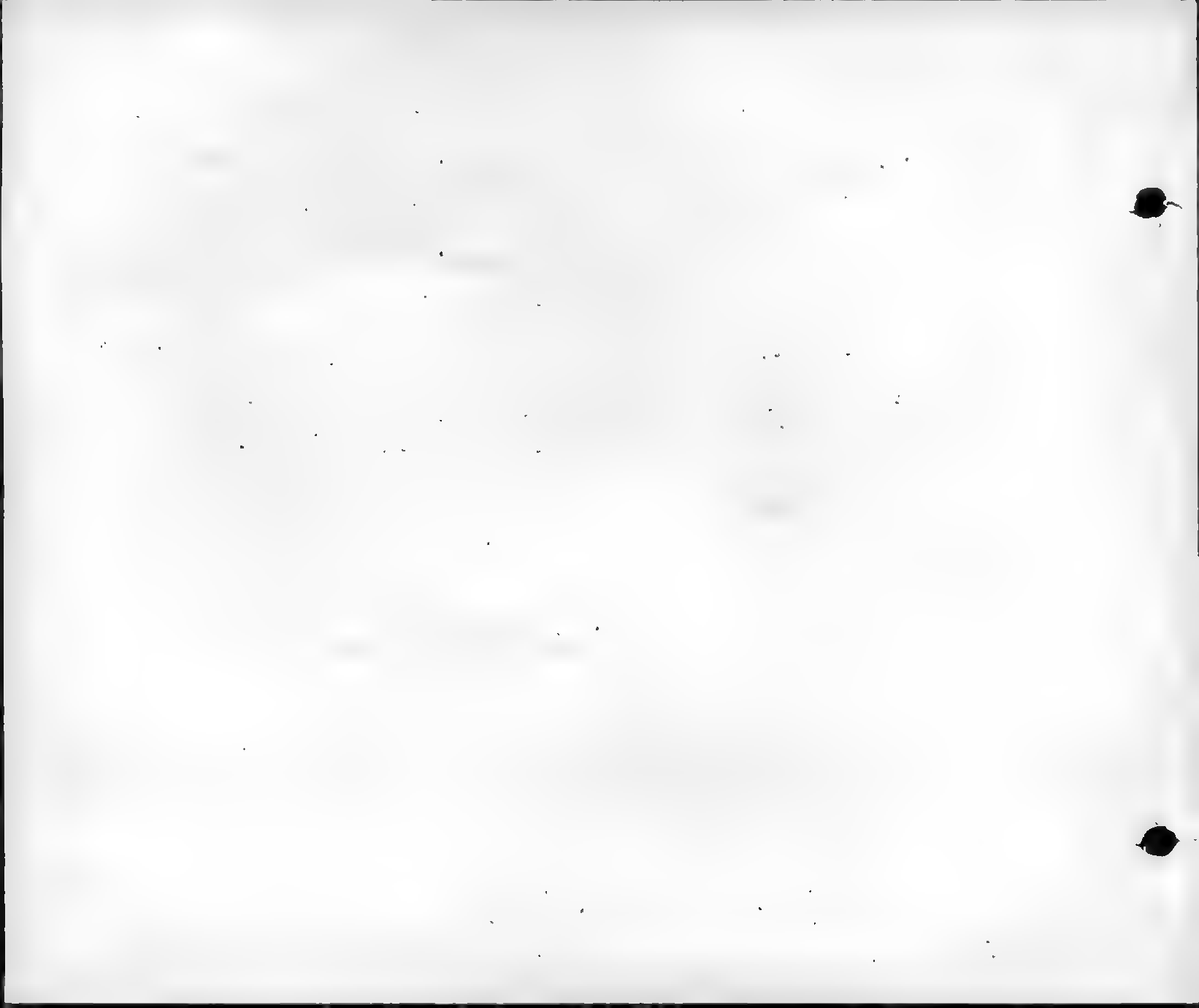
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring Md.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>8500 N. H. Ave</i>		e. STREET ADDRESS <i>8500 NEW HAMPSHIRE AVE</i>	
3. NAME OF DECEASED (Type or print) First <i>Mark</i> Middle Last <i>Meyers</i>		4. DATE OF DEATH Month <i>10</i> Day <i>9</i> Year <i>1960</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 27, 1902</i>
9. AGE (In years last birthday) yrs. <i>58</i>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Furniture Salesman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>London England</i>	
11. BIRTHPLACE (State or foreign country) <i>USA</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Philip Meyers</i>		14. MOTHER'S MAIDEN NAME <i>Jennie Davis</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO. <i>INFORMANT</i> Address <i>Leo Deckelbaum</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> DUE TO <i>Coronary Sclerosis</i> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary Sclerosis</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i> <i>10 yrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cardiomegaly, Auricular Fibrillation</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>1960</i> to <i>10-9</i> , 1960, that I lost saw the deceased alive on <i>10-8</i> , 1960, and that death occurred at <i>11 A.M.</i> from the causes and on the date stated above ADDRESS (Street, city or town, state) <i>915-19th St. N.W. Wash. D.C.</i> DATE SIGNED			
ACTUAL SIGNATURE <i>Louis Ross</i>		M.D. <i>915-19th St. N.W. Wash. D.C.</i>	
PHYSICIAN'S NAME (Type) <i>Louis Ross</i>			
22a. BURIAL CREMATION APPROVAL (Specify) <i>Burial Oct 14, 1960</i>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <i>Beth Shalom</i>	22d. LOCATION (City, town, or county) (State) <i>Washington D.C.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>B. Dargansky & Sons</i>		24a. REC'D BY REGISTRAR DATE <i>OCT 11 '60</i>	
ADDRESS <i>3501-14 St NW</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur E. Hines</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

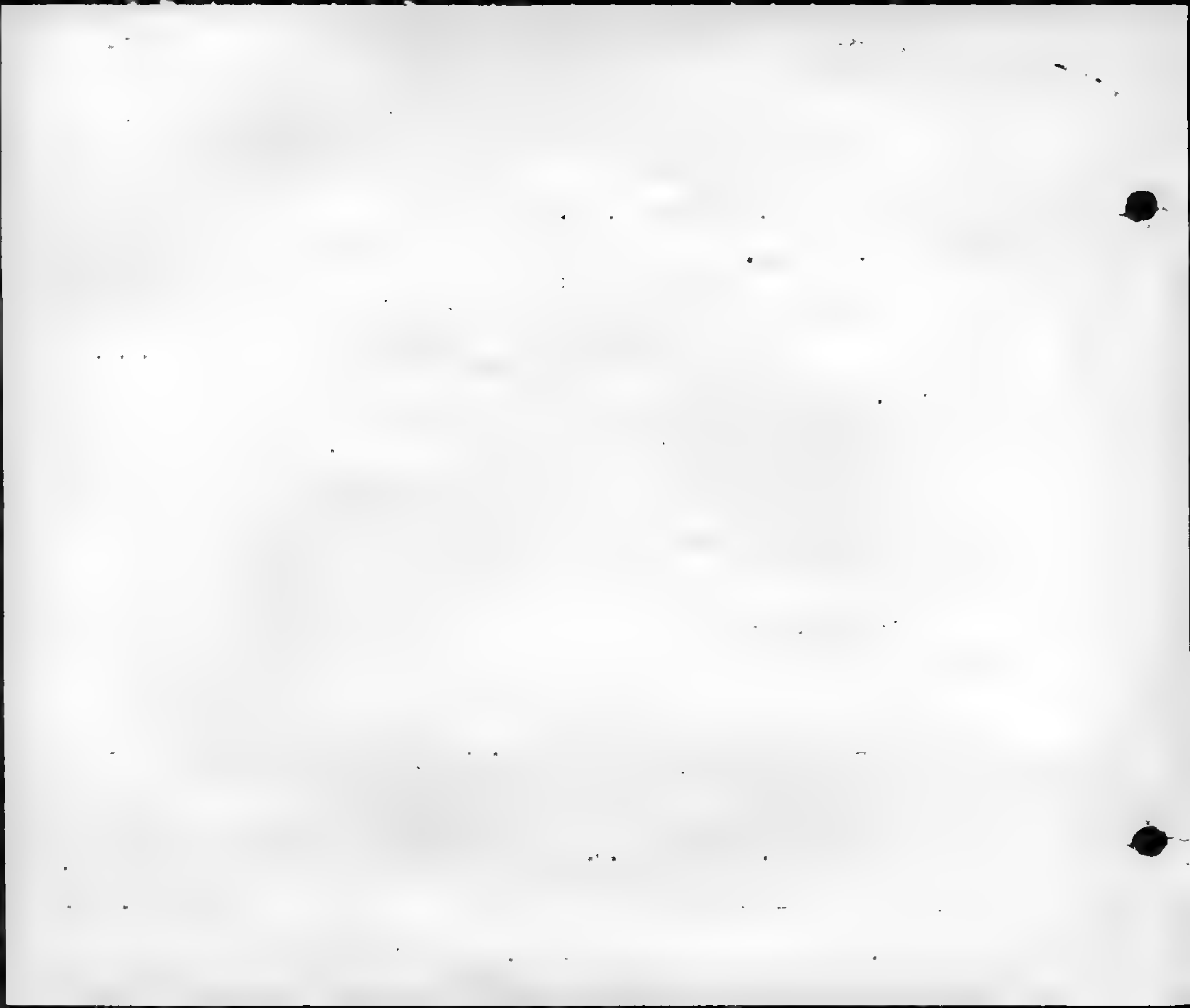
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11629

11585

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 49 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berkley Springs		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS Route # 1		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First June Middle Viola Last Mills		4. DATE OF DEATH Month October Day 22 Year 1960					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 17, 1949		9. AGE (In years last birthday) 11 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Clarence J. Mills			14. MOTHER'S MAIDEN NAME June Salmon				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia 204.3 DUE TO Acute Myelogenous Leukemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH 4 weeks + 6 months						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Atelectasis, marked							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (†) (this hospital) attended the deceased from Sept. 3, 1960 to October 22, 1960 , that (†) (we) last saw the deceased alive on October 22, 1960 , and that death occurred at 3:30 PM from the causes and on the date stated above.							
22a. SIGNATURE <i>Robert B. Scoggins</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 10/22/60		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Robert B. Scoggins, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.					
23a. BURIAL, CREMATION, REMOVA. (Specify) Burial-transit		23b. DATE THEREOF 10-23-60		23c. NAME OF CEMETERY OR CREMATORY Greenway Cemetery		23d. LOCATION (City, town, or county) (State) Berkley Springs, W. Va.	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.		25a. REC'D BY REGISTRAR DATE OCT 25 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



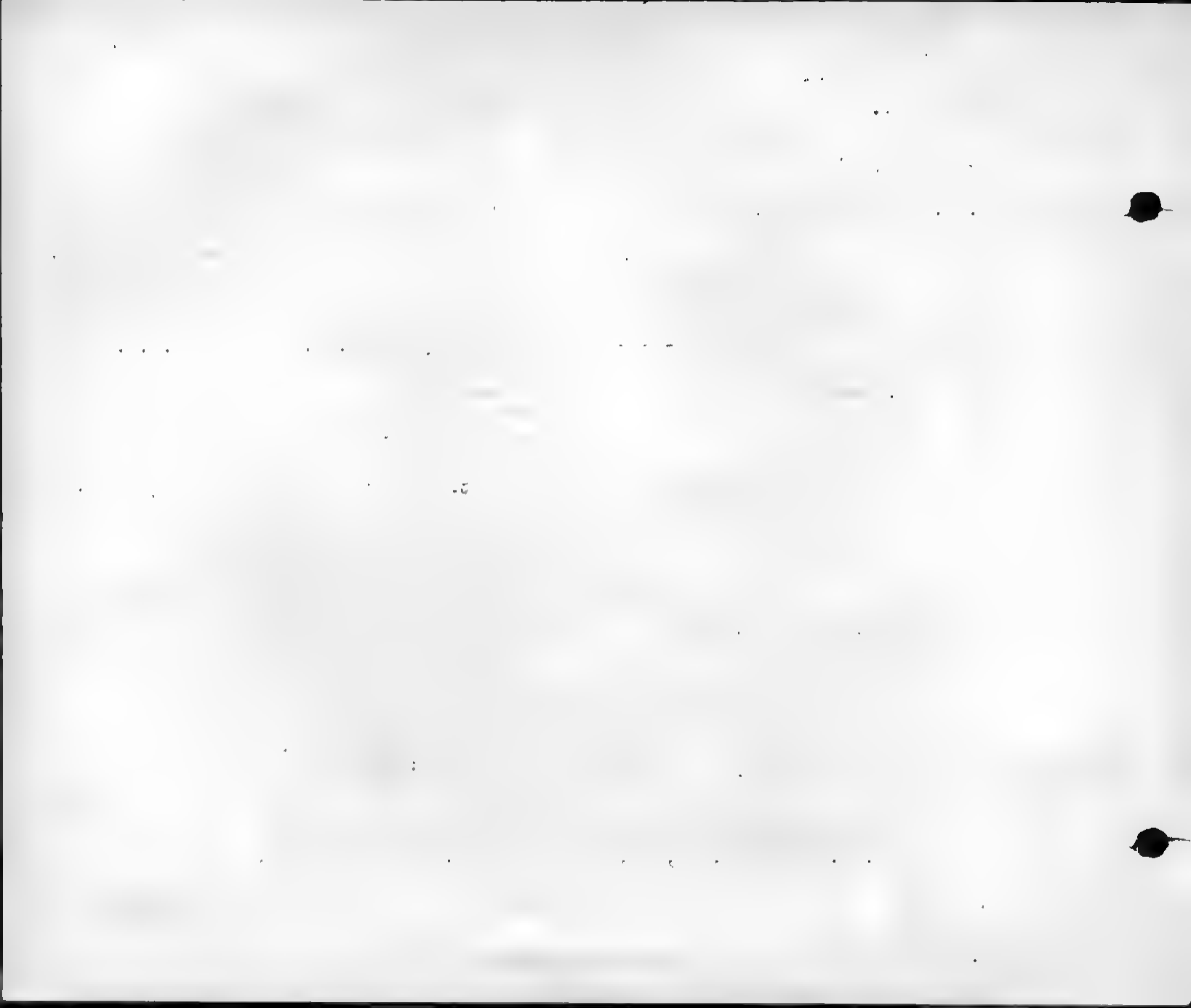
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11630

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11586

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 175 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase d. STREET ADDRESS 4707 Chevy Chase Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ellen Middle Hayes Last Mitchell			4. DATE OF DEATH Month October Day 4 Year 1960				
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 11-17-96		9. AGE (In years last birthday) 63 yrs		10. IF UNDER 1 YEAR Months 6 Days 3 Hours 15 Min			
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Washington, D. C.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles W. Hayes		14. MOTHER'S MAIDEN NAME Rosa Paige			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic carcinoma, r.p. cerebral hemisphere DUE TO (Primary site undetermined) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bilateral Lobular Pneumonia 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 10:40PM			
20f. (City or town) Suitland		20g. (County) Maryland		20h. (State) Maryland			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 12, 1960 to Oct. 4, 1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Oct. 4, 1960 , and that death occurred at 10:40PM , from the causes and on the date stated above							
22a. SIGNATURE C. W. BRAMLETT, LT, MC, USN		22b. DATE SIGNED 10-5-60		22c. PHYSICIAN'S NAME (Type) C. W. BRAMLETT, LT, MC, USN			
23a. BURIAL CREMATION REMOVAL (Specify) Cremation		23b. DATE THEREOF 10-6-60		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory			
23d. LOCATION (City, town, or county) Suitland		23e. (State) Maryland		23f. (Country) Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawler's & Sons		24a. ADDRESS 1756 Penn. Ave. NW, WashDC		25a. REC'D BY REGISTRAR OCT 10 '60			
25b. REGISTRAR'S SIGNATURE Arthur S. Frank		25c. REGISTRAR'S NAME Arthur S. Frank					

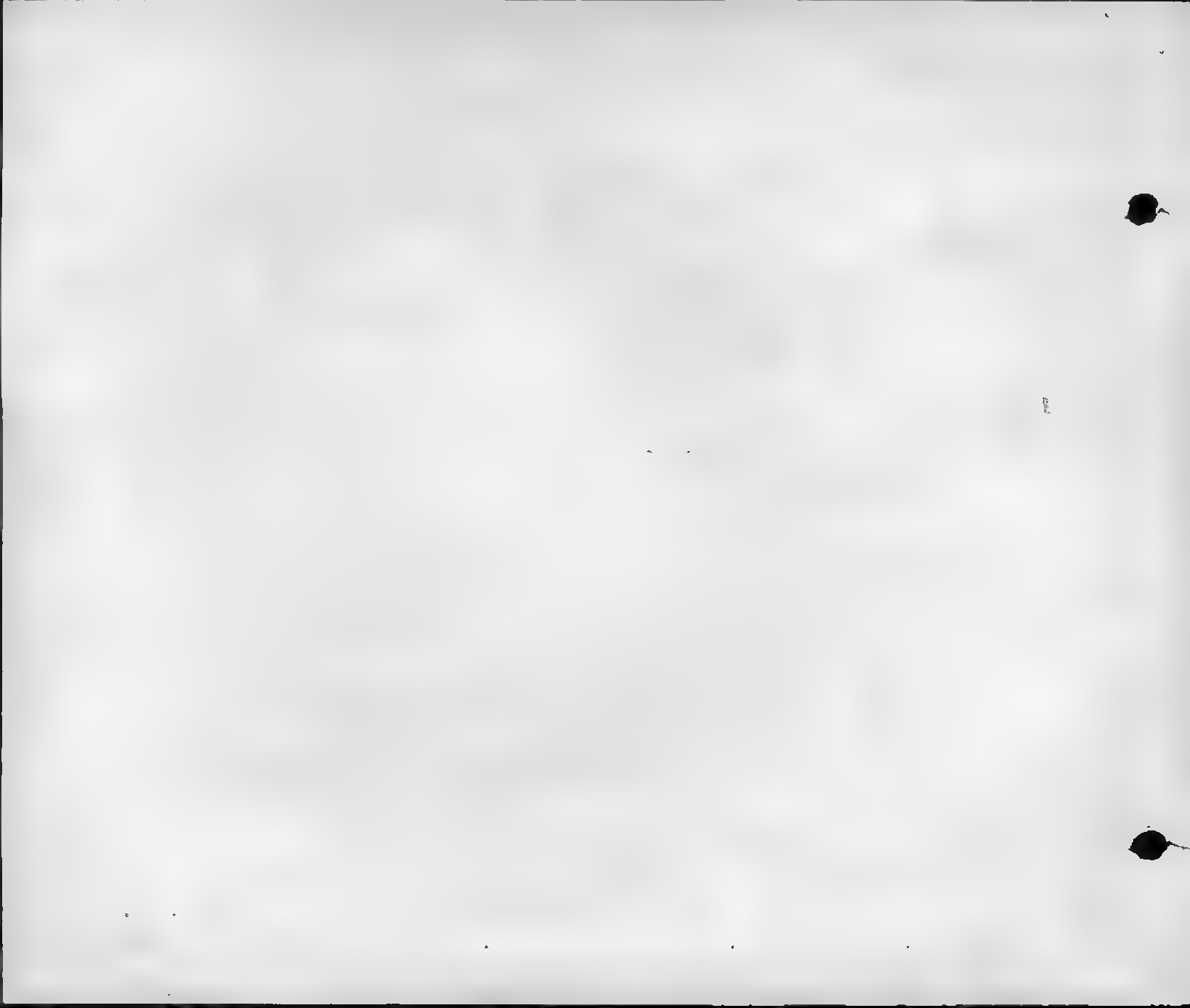


TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>md</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY in 1b <u>8 yrs</u>		d. STREET ADDRESS <u>2001 August Dr</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2001 August Dr</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles William Mohler</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>17</u> Year <u>1960</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-23-1892</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>17</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Motion picture projectionist</u>		11. BIRTHPLACE (State or foreign country) <u>Va</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>George Mohler</u>	
14. MOTHER'S MAIDEN NAME <u>Blanche Huntington</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>578-01-5302</u>		17. INFORMANT <u>Elsie Mohler (wife)</u> Address <u>Stun 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c) _____ DUE TO cause listed. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) _____ 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____ 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) _____ (County) _____ (State) _____		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/19/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN CEMETERY</u>		22d. LOCATION (City, town, or country) (State) <u>MONTGOMERY COUNTY, MD.</u>	
23. FUNERAL DIRECTOR ADDRESS <u>WARNER E. PUMPHREY, INC.</u> <u>1500 E. J. Ziska</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 21 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>		DATE SIGNED <u>10-17-60</u>	



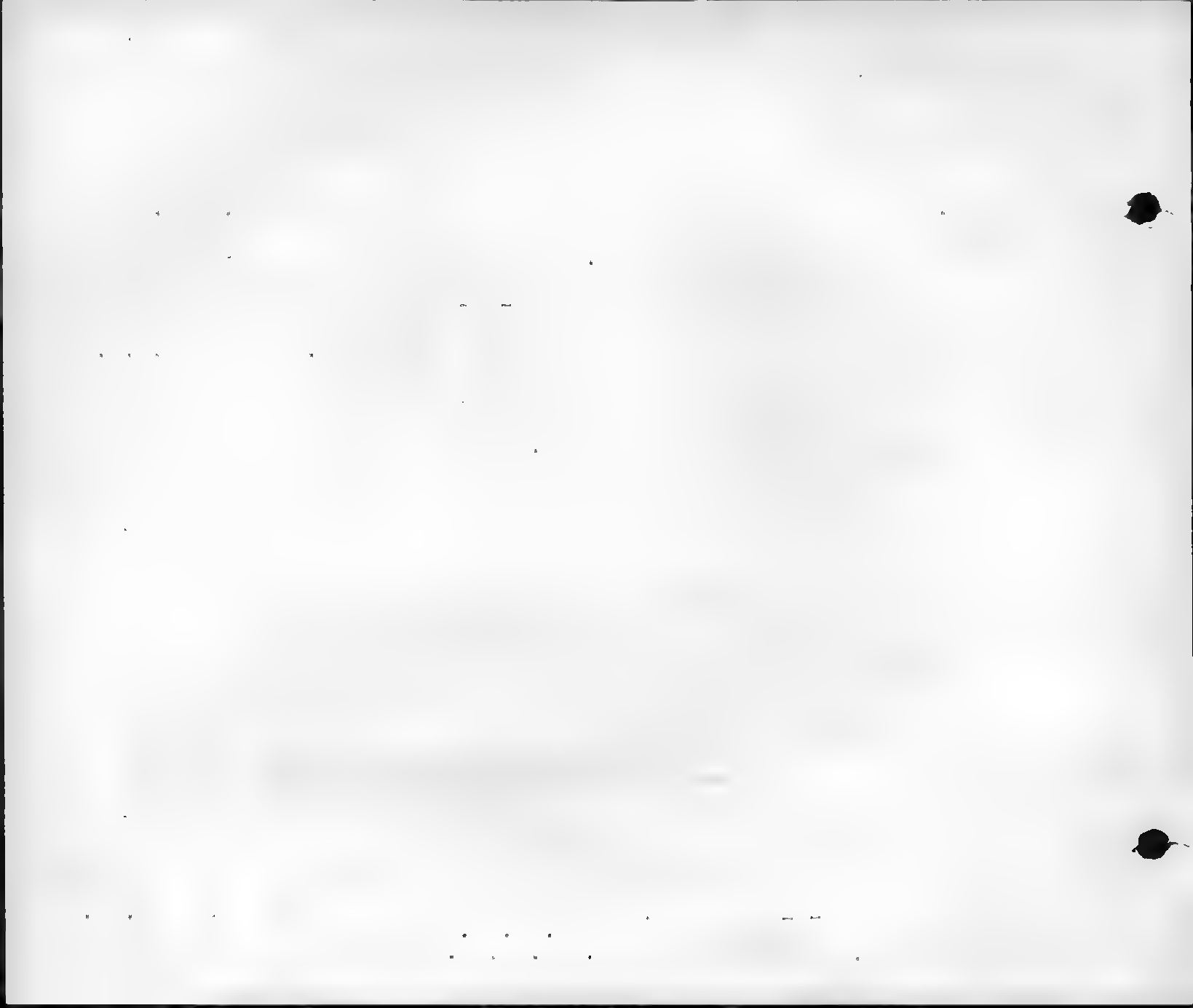
1

11631

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11588

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY 1			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NORBECK				c. LENGTH OF STAY IN 1b 5 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ST. PHILOMENA'S REST HOME				d. STREET ADDRESS 4752 EASTERN AVE. N.E.		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle L. Last Morris				4. DATE OF DEATH Month 10- Day 3 Year 1960			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-21-83	
9. AGE (In years lost b rthday) 77 yrs		F UNDER 1 YEAR Months 7 Days 7 Hours 7 Min 7		IF UNDER 24 HRS Months 7 Days 7 Hours 7 Min 7			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) WASHINGTON, D. C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME CHARLES MILLER				14. MOTHER'S MAIDEN NAME JULIA TRACEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT W. CHARLES MORRIS (SA - A - 2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Failure 42 42 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriosclerotic Heart Disease (c) Bronchopneumonia				INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 20 years 48 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Jan 5 1957 to Oct. 3 1960 that (I) (we) last saw the deceased alive on Sept 26 1960 , and that death occurred at 10:20 A.M. from the causes and on the date stated above							
22a. SIGNATURE Harry J. Kicherer				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-3-60	
22c. PHYSICIAN'S NAME (Type) Harry J. Kicherer				22d. ADDRESS 5527 Surrey St., Chevy Chase, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-6-60		23c. NAME OF CEMETERY OR CEMETORY MT. OLIVET CEMETERY		23d. LOCATION (City, town, or county) (State) WASHINGTON, D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins				ADDRESS WASH. D. C. 3821 14th. ST. N. W.		25a. REC'D. BY REGISTRAR Oct 6 1960 25b. REGISTRAR'S SIGNATURE Robert A. ...	



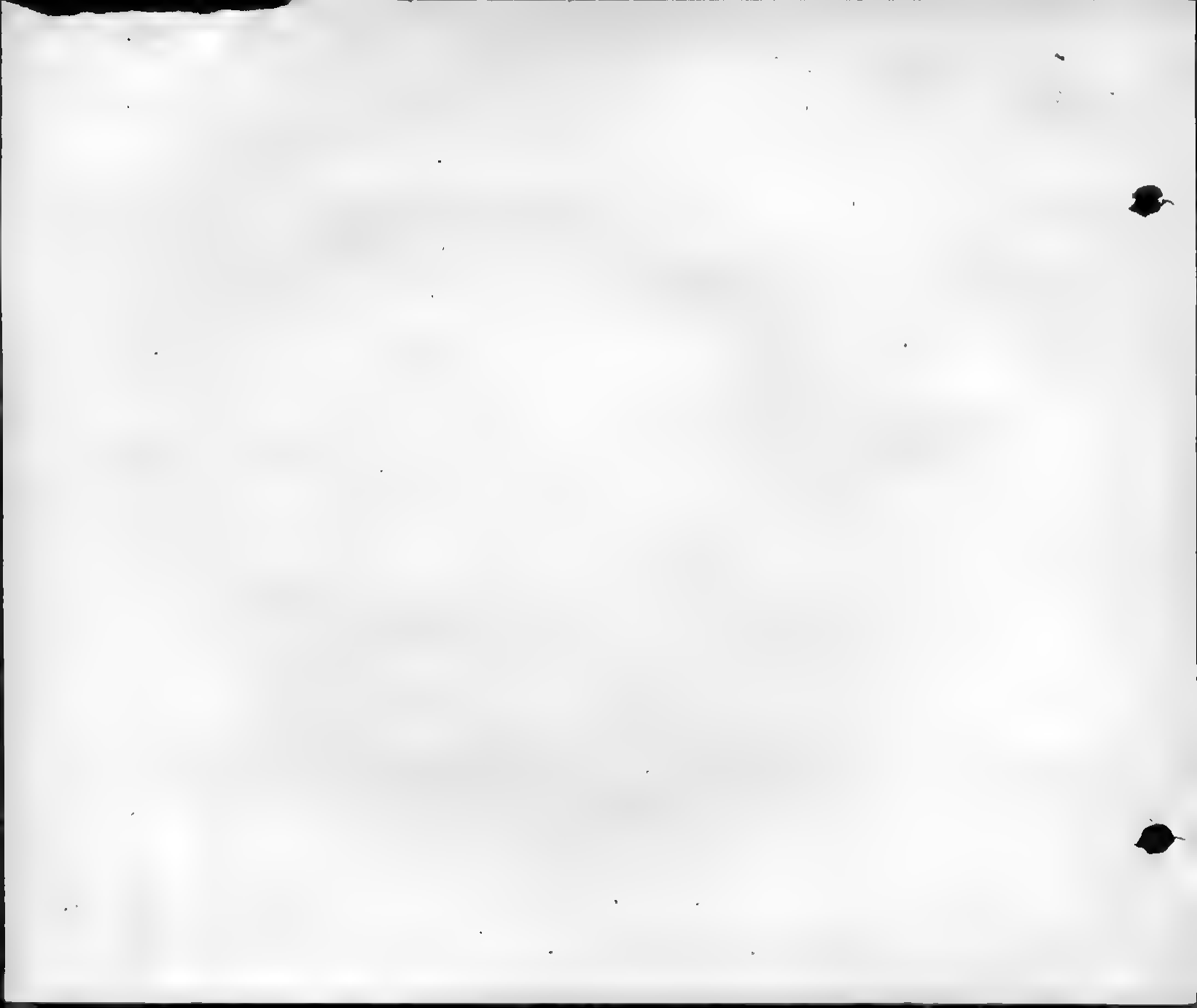
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11589

11632

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b X CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban				d. STREET ADDRESS 657 Husten Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)		First Laura Middle V Last Moyer		4. DATE OF DEATH		Month 10 Day 14 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/18/08	9. AGE (In years last birthday) 52 yrs	IF UNDER 1 YEAR Months 52 Days 10 Hours 14 Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Hayes Bowman				14. MOTHER'S MAIDEN NAME Laura Virginia			
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 577-01-6244		17. INFORMANT John A Moyer		Address same 2 d Husband	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrovascular accident DUE TO (b) generalized atherosclerosis DUE TO (c) diabetes mellitus Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH 2 days 5 yrs 5 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Atherosclerotic heart disease							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-14-1960 to 10-14-1960 that (I) (we) last saw the deceased alive on 10-14-1960 , and that death occurred at 2:45 PM , from the causes and on the date stated above.							
22a. SIGNATURE Stephen W. DeJter		M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 10-14-60			
22c. PHYSICIAN'S NAME (Type) STEPHEN W. DEJTER, M.D.		22d. ADDRESS 6715 WILSON LA., BETHESDA MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-17-60		23c. NAME OF CEMETERY OR CREMATORY Salem Church Cem.		23d. LOCATION (City, town, or county) (State) Montgomery County, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Rumphrey				ADDRESS Bethesda, Md.		25a. REC'D BY REGISTRAR DATE OCT 18 '60	
				25b. REGISTRAR'S SIGNATURE Arthur L. Howard			



11512

UNITED STATES DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

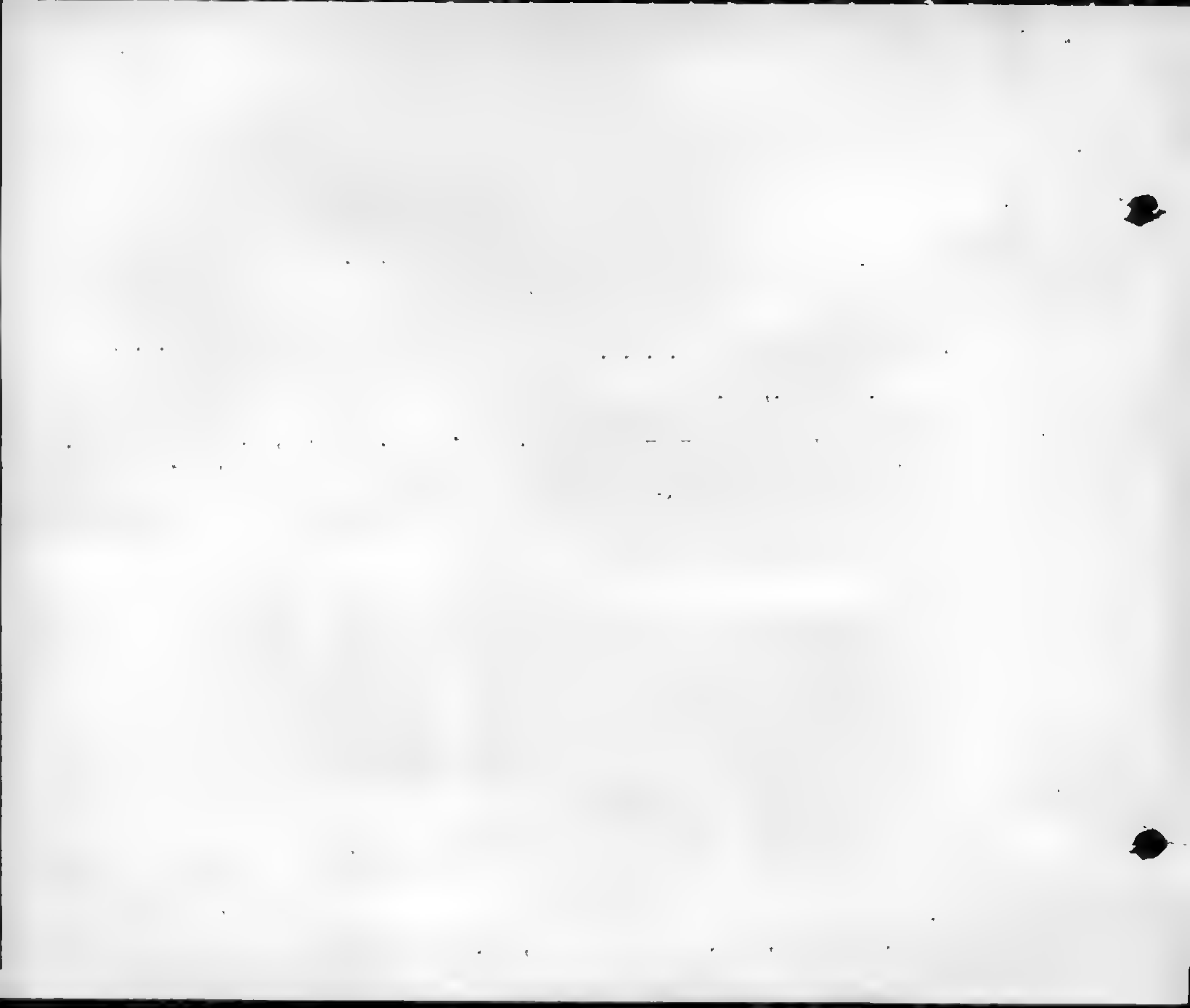
11590

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 1 year			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				d. STREET ADDRESS 1415 HILLSBORO DRIVE			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Daniel Henry Murphey, Jr.				4. DATE OF DEATH Oct 13 1960			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/30/14	9. AGE (In years last birthday) 46 yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Director of Procurement		10b. KIND OF BUSINESS OR INDUSTRY N.A.S.A.		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DANIEL H. MURPHEY, SR.				14. MOTHER'S MAIDEN NAME HELEN COSGROVE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO WW # 2 185-09-6095		17. INFORMANT Mrs. Margaret H. Murphey, 415 Hillsboro Dr., Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis (b) Chronic Coronary Sclerosis (c) Undetermined Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary Thrombosis (old) 4 months							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a m _____ p m _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 8 1960 to Oct 13 1960 , that (I) (we) lost the deceased alive on Sept 17 60 and that death occurred on Oct 13 1960 from the causes and on the date stated above							
22a. SIGNATURE George L Ball		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED Oct 13, 1960			
22c. PHYSICIAN'S NAME (Type) George L Ball		22d. ADDRESS 10620 Lehigh Ave Silver Spring Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL 10/17/60		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY		23d. LOCATION (City, town, or county) (State) PHILADELPHIA, PENNSYLVANIA	
24. FUNERAL DIRECTOR'S SIGNATURE WARNER E. POMPHELY, INC.		ADDRESS SILVER SPRING, MD.		25a. REC'D BY REGISTRAR DATE OCT 19 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Coroner Brochard notified circumstances of this death and he authorized me to sign certificate.



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11536

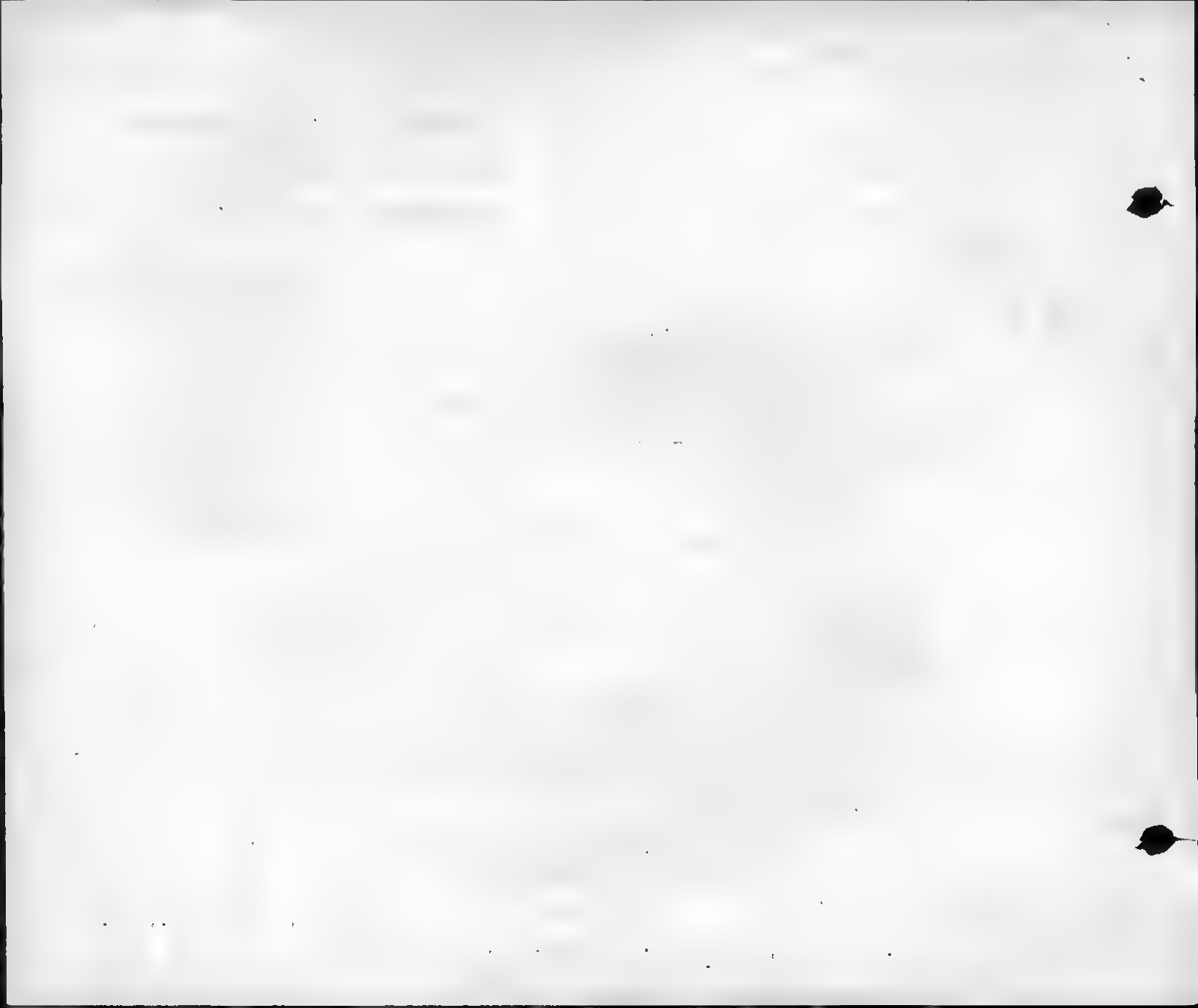
11591

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE [Where deceased lived If institution: Residence before admission] a. STATE <u>Pennsylvania</u> PA. b. COUNTY <u>MONTGOMERY</u> MERCER			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, MD</u>				c. LENGTH OF STAY IN 1b <u>9 1/2 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Gen. & Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Samuel NM IV NEGREA</u>				4. DATE OF DEATH Month Day Year <u>10 - 9 1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-29-12</u>	9. AGE (In years last birthday) <u>48</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Hours Min	
10a. USUAL OCCUPATION (Give kind of work done, if retired) <u>General Manager</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Fabrics</u>		11. BIRTHPLACE (State or foreign country) <u>Penn.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Nicholas Negrea</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>278-10-1493</u>		17. INFORMANT <u>Chart Wash. Gen. & Hosp.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>MYOCARDIAL FAILURE</u> <u>434.4</u> DUE TO (b) <u>SEVERE CARDIAC DILATATION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Thrombosis Right Iliac Vein</u>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>8 OCTOBER, 1960</u> , to <u>9 OCTOBER, 1960</u> , that (I) <u>was</u> last saw the deceased alive on <u>9 OCTOBER, 1960</u> , and that death occurred at <u>9:20 AM</u> , from the causes and on the date stated above							
22a. SIGNATURE <u>Morrill C. Quinnam Jr.</u> M.D.				22b. ADDRESS <u>7600 CARROLL AVE., TAKOMA PARK, MD.</u>		22c. PHYSICIAN'S NAME (Type) <u>MORRILL C. QUINNAM JR., M.D.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>10/12/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>OAKWOOD CEMETERY</u>	
23d. LOCATION (City, town, or county) (State) <u>SHARON MERCER CO., PA.</u>				25a. REC'D BY REGISTRAR <u>Arthur S. Kline</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC., SILVER SPRING, MD.</u>				25a. DATE <u>OCT 11 '60</u>			

MEDICAL CERTIFICATION

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any further information is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

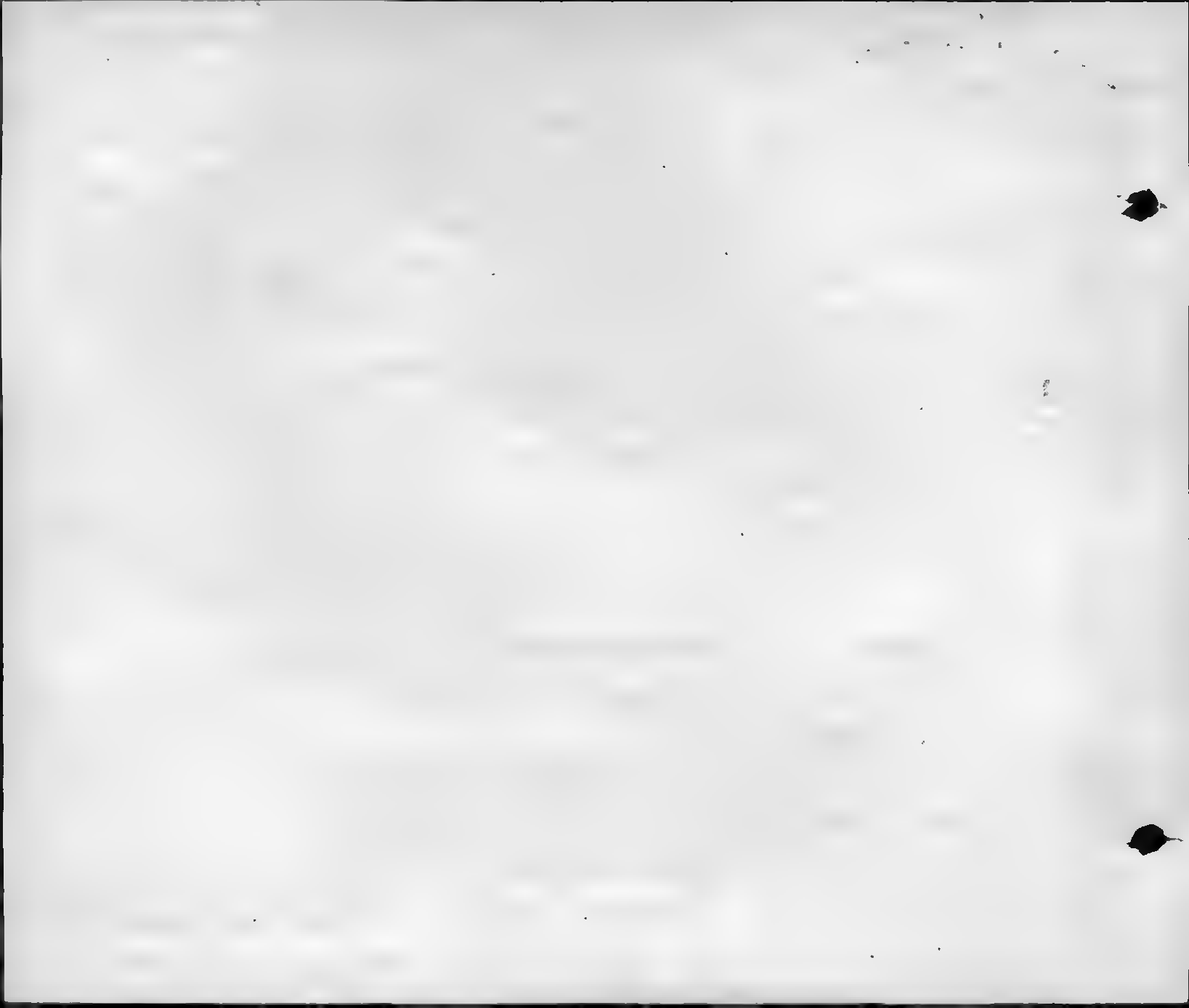
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11559

11592

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
c. LENGTH OF STAY IN 1b <u>life</u>		d. STREET ADDRESS <u>201 N. Van Buren st</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Robert Worth Nicewarmer</u>		f. DATE OF DEATH <u>Oct 27 1960</u>	
5. SEX <u>male</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH <u>11-4-1957</u>	
6. COLOR OR RACE <u>white</u>		9. AGE (In years last birthday) <u>2</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <u>md</u>	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C</u>	
13. FATHER'S NAME <u>Robt. Nicewarmer</u>		14. MOTHER'S MAIDEN NAME <u>Nancy West</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Nancy Nicewarmer</u>		Address <u>Stuen</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral edema with herniation of brain stem</u> DUE TO (b) <u>Anoxia secondary to pulmonary edema</u> DUE TO (c) <u>Pneumonitis, etiology indeterminate</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Sudden</u> <u>days</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22b. DATE THEREOF <u>10/29/60</u>		DATE SIGNED <u>10-27-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u>		Address (Street, city, town or county)	
22d. LOCATION (City, town, or country) (State) <u>Rockville, Maryland</u>		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
DATE <u>OCT 31 '60</u>		<u>Charles P. Pumphrey</u>	



11537

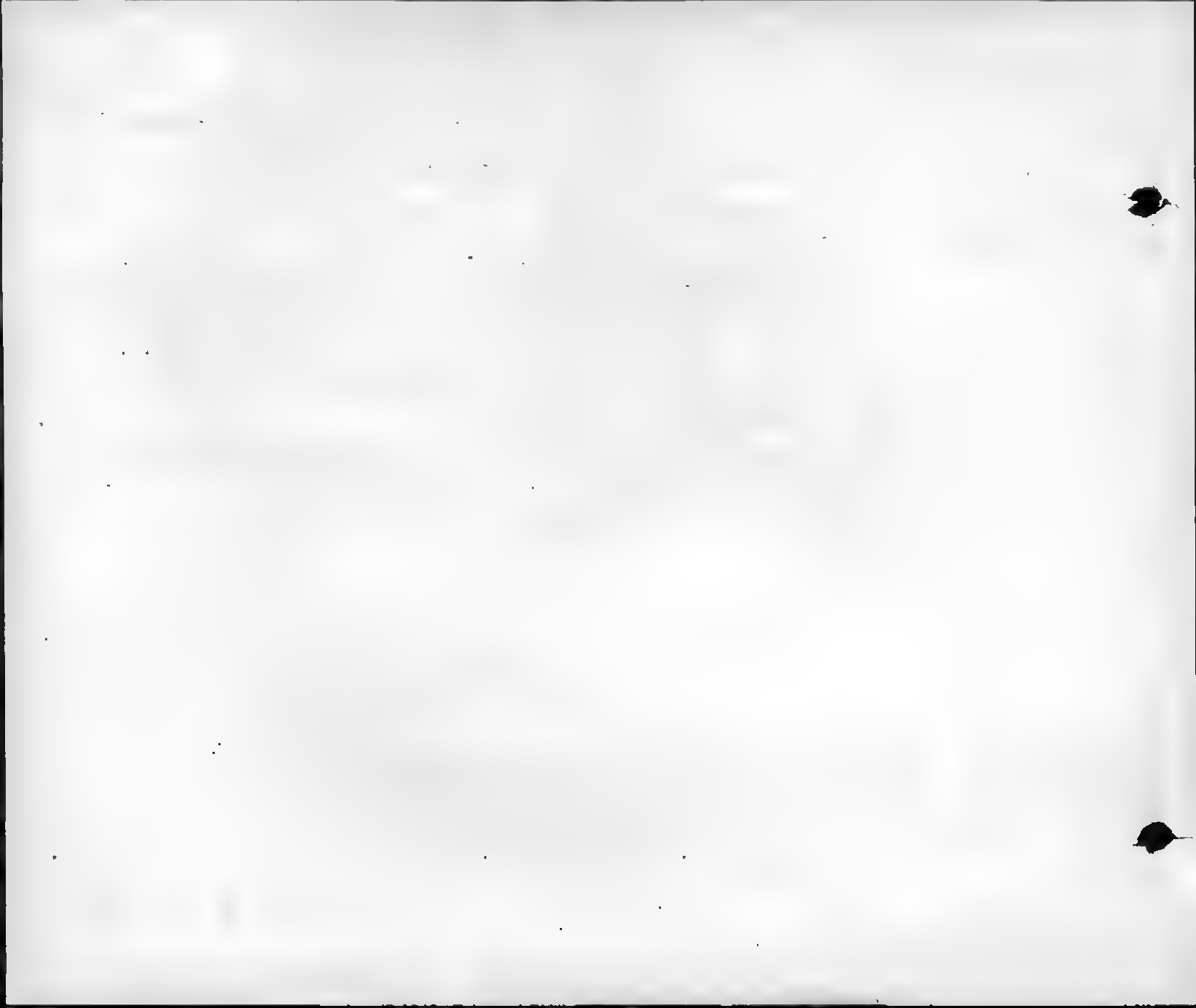
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11593

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7517 MAPLE AVE.</u>				d. STREET ADDRESS <u>7517 MAPLE AVE</u>			
3. NAME OF DECEASED (Type or print) First <u>PATRICIA</u> Middle <u>NISWANDER</u> Last <u>NISWANDER</u>				4. DATE OF DEATH Month <u>OCT.</u> Day <u>23</u> Year <u>1960</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 30, 1934</u>	
9. AGE (In years last birthday) <u>25</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife & schoolteacher</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Rock Hall Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Roland Perry</u>				14. MOTHER'S MAIDEN NAME <u>Mario Savage</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO		17. INFORMANT Address <u>Md. Ronald Niswander, 7517 Maple Ave, Takoma Park</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> <u>434.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cor Pulmonale</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>none</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6:25 PM</u> to present date <u>10/23/60</u> . that (I) (we) last saw the deceased alive on <u>Oct 19</u> 19 <u>60</u> and that death occurred at <u>MD</u> from the causes and on the date stated above							
22a. SIGNATURE <u>R. H. Sandstrom</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>Oct 23, 60</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. H. Sandstrom M. D.</u>				22d. ADDRESS <u>10202 Lariston Lane, Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>OCT 26, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GEORGE WASHINGTON CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>PR. GEO. COUNTY MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles D. Taylor</u>				25a. REC'D BY REGISTRAR <u>254 CARROLL ST. N. W.</u>		25b. REGISTRAR'S SIGNATURE <u>Oct 26 '60</u>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

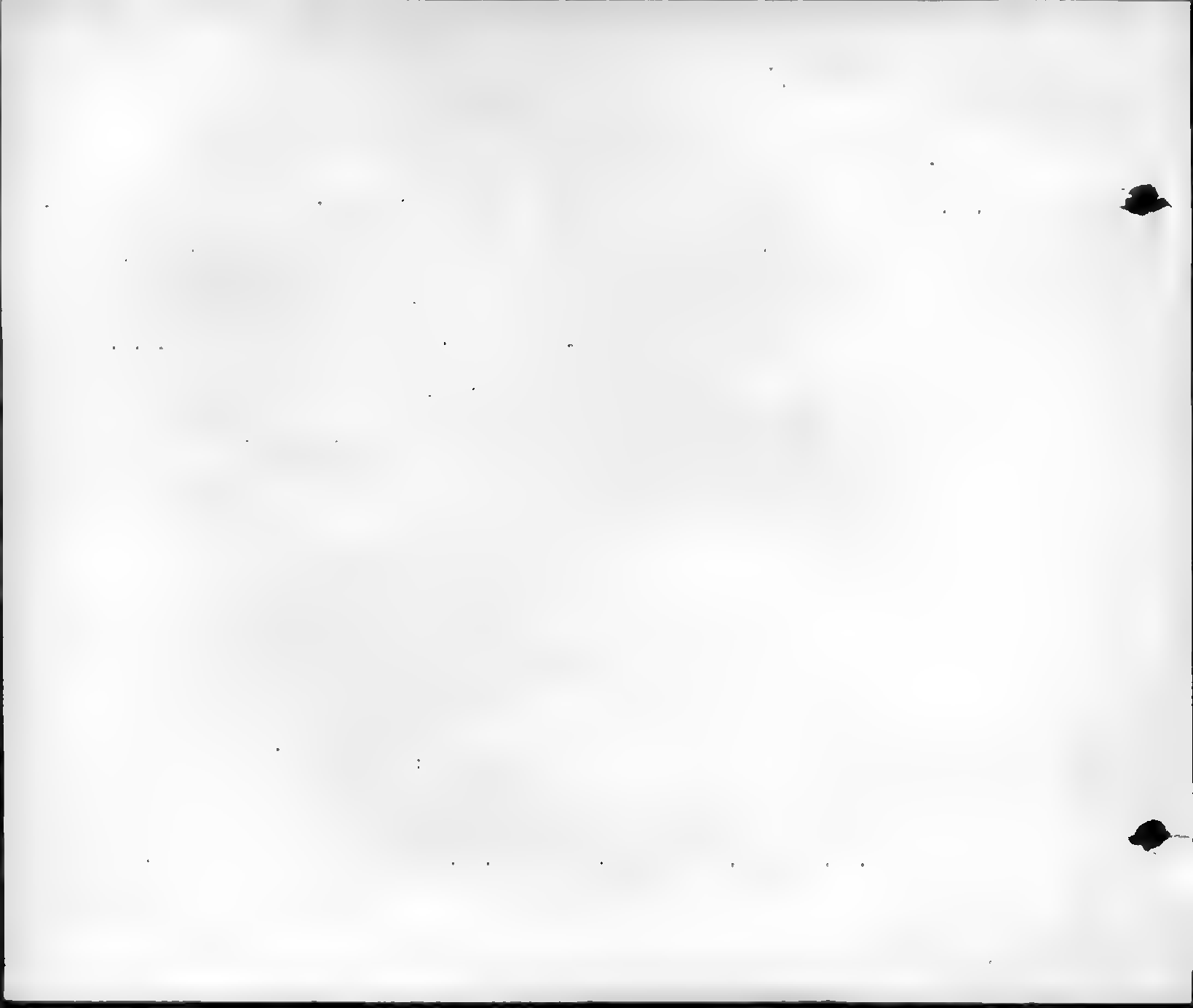
VR A15 (4)
ISM 9/58

11633

11594

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 74 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington d. STREET ADDRESS 10400 Parkwood Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sarah Middle May Last OEHMKE		4. DATE OF DEATH Month October Day 27 Year 19 60	
5. SEX Female		6. COLOR OR RACE Caucasian	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-10-21	
9. AGE (In years last birthday) 39 yrs		10. IF UNDER 1 YEAR Months 39	
11. IF UNDER 24 HRS Days 39		12. IF UNDER 24 HRS Hours 39	
13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		14. KIND OF BUSINESS OR INDUSTRY Massachusetts	
15. BIRTHPLACE (State or foreign country) Massachusetts		16. CITIZEN OF WHAT COUNTRY? U.S.A.	
17. FATHER'S NAME Thomas DONAHUE		18. MOTHER'S MAIDEN NAME Mary A. LYONS	
19. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		20. SOCIAL SECURITY NO. (H) Arthur L. Oehmke, same as #2 above	
21. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma breast with metastases DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 170x DUE TO (c) 3 yrs.		22. INTERVAL BETWEEN ONSET AND DEATH 3 yrs.	
23. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		24. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
25. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		26. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
27. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		28. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
29. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		30. (City or town) (County) (State)	
31. I certify that (he) (this hospital) attended the deceased from August 14, 1960 to Oct. 27, 1960 that (he) (we) last saw the deceased alive on Oct. 27, 1960 , and that death occurred at 5:53 AM , from the causes and on the date stated above		32. SIGNATURE E. J. Rupnik M. D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. ADDRESS U. S. Naval Hospital, Bethesda, Md. 22c. PHYSICIAN'S NAME (Type) E. J. RUPNIK, CDR, MC, USN 22d. DATE SIGNED 10-27-60	
33. BURIAL, CREMATION, REMOVAL (Specify) Burial		34. DATE THEREOF 10-31-60	
35. NAME OF CEMETERY OR CREMATORY Arlington National		36. LOCATION (City, town, or county) (State) Arlington Virginia	
37. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey ADDRESS R. A. Pumphrey Funeral Home, Bethesda, Md.		38. REC'D BY REGISTRAR DATE OCT 28 '60	
39. REGISTRAR'S SIGNATURE Arthur L. Oehmke		40. REGISTRAR'S SIGNATURE Arthur L. Oehmke	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be reissued by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11634

11595

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

28

29

30

31

32

33

34

35

36

37

38

39

40

41

42

43

44

45

46

47

48

49

50

51

52

53

54

55

56

57

58

59

60

61

62

63

64

65

66

67

68

69

70

71

72

73

74

75

76

77

78

79

80

81

82

83

84

85

86

87

88

89

90

91

92

93

94

95

96

97

98

99

100

101

102

103

104

105

106

107

108

109

110

111

112

113

114

115

116

117

118

119

120

121

122

123

124

125

126

127

128

129

130

131

132

133

134

135

136

137

138

139

140

141

142

143

144

145

146

147

148

149

150

151

152

153

154

155

156

157

158

159

160

161

162

163

164

165

166

167

168

169

170

171

172

173

174

175

176

177

178

179

180

181

182

183

184

185

186

187

188

189

190

191

192

193

194

195

196

197

198

199

200

201

202

203

204

205

206

207

208

209

210

211

212

213

214

215

216

217

218

219

220

221

222

223

224

225

226

227

228

229

230

231

232

233

234

235

236

237

238

239

240

241

242

243

244

245

246

247

248

249

250

251

252

253

254

255

256

257

258

259

260

261

262

263

264

265

266

267

268

269

270

271

272

273

274

275

276

277

278

279

280

281

282

283

284

285

286

287

288

289

290

291

292

293

294

295

296

297

298

299

300

301

302

303

304

305

306

307

308

309

310

311

312

313

314

315

316

317

318

319

320

321

322

323

324

325

326

327

328

329

330

331

332

333

334

335

336

337

338

339

340

341

342

343

344

345

346

347

348

349

350

351

352

353

354

355

356

357

358

359

360

361

362

363

364

365

366

367

368

369

370

371

372

373

374

375

376

377

378

379

380

381

382

383

384

385

386

387

388

389

390

391

392

393

394

395

396

397

398

399

400

401

402

403

404

405

406

407

408

409

410

411

412

413

414

415

416

417

418

419

420

421

422

423

424

425

426

427

428

429

430

431

432

433

434

435

436

437

438

439

440

441

442

443

444

445

446

447

448

449

450

451

452

453

454

455

456

457

458

459

460

461

462

463

464

465

466

467

468

469

470

471

472

473

474

475

476

477

478

479

480

481

482

483

484

485

486

487

488

489

490

491

492

493

494

495

496

497

498

499

500

501

502

503

504

505

506

507

508

509

510

511

512

513

514

515

516

517

518

519

520

521

522

523

524

525

526

527

528

529

530

531

532

533

534

535

536

537

538

539

540

541

542

543

544

545

546

547

548

549

550

551

552

553

554

555

556

557

558

559

560

561

562

563

564

565

566

567

568

569

570

571

572

573

574

575

576

577

578

579

580

581

582

583

584

585

586

587

588

589

590

591

592

593

594

595

596

597

598

599

600

601

602

603

604

605

606

607

608

609

610

611

612

613

614

615

616

617

618

619

620

621

622

623

624

625

626

627

628

629

630

631

632

633

634

635

636

637

638

639

640

641

642

643

644

645

646

647

648

649

650

651

652

653

654

655

656

657

658

659

660

661

662

663

664

665

666

667

668

669

670

671

672

673

674

675

676

677

678

679

680

681

682

683

684

685

686

687

688

689

690

691

692

693

694

695

696

697

698

699

700

701

702

703

704

705

706

707

708

709

710

711

712

713

714

715

716

717

718

719

720

721

722

723

724

725

726

727

728

729

730

731

732

733

734

735

736

737

738

739

740

741

742

743

744

745

746

747

748

749

750

751

752

753

754

755

756

757

758

759

760

761

762

763

764

765

766

767

768

769

770

771

772

773

774

775

776

777

778

779

780

781

782

783

784

785

786

787

788

789

790

791

792

793

794

795

796

797

798

799

800

801

802

803

804

805

806

807

808

809

810

811

812

813

814

815

816

817

818

819

820

821

822

823

824

825

826

827

828

829

830

831

832

833

834

835

836

837

838

839

840

841

842

843

844

845

846

847

848

849

850

851

852

853

854

855

856

857

858

859

860

861

862

863

864

865

866

867

868

869

870

871

872

873

874

875

876

877

878

879

880

881

882

883

884

885

886

887

888

889

890

891

892

893

894

895

896

897

898

899

900

901

902

903

904

905

906

907

908

909

910

911

912

913

914

915

916

917

918

919

920

921

922

923

924

925

926

927

928

929

930

931

932

933

934

935

936

937

938

939

940

941

942

943

944

945

946

947

948

949

950

951

952

953

954

955

956

957

958

959

960

961

962

963

964

965

966

967

968

969

970

971

972

973

974

975

976

977

978

979

980

981

982

983

984

985

986

987

988

989

990

991

992

993

994

995

996

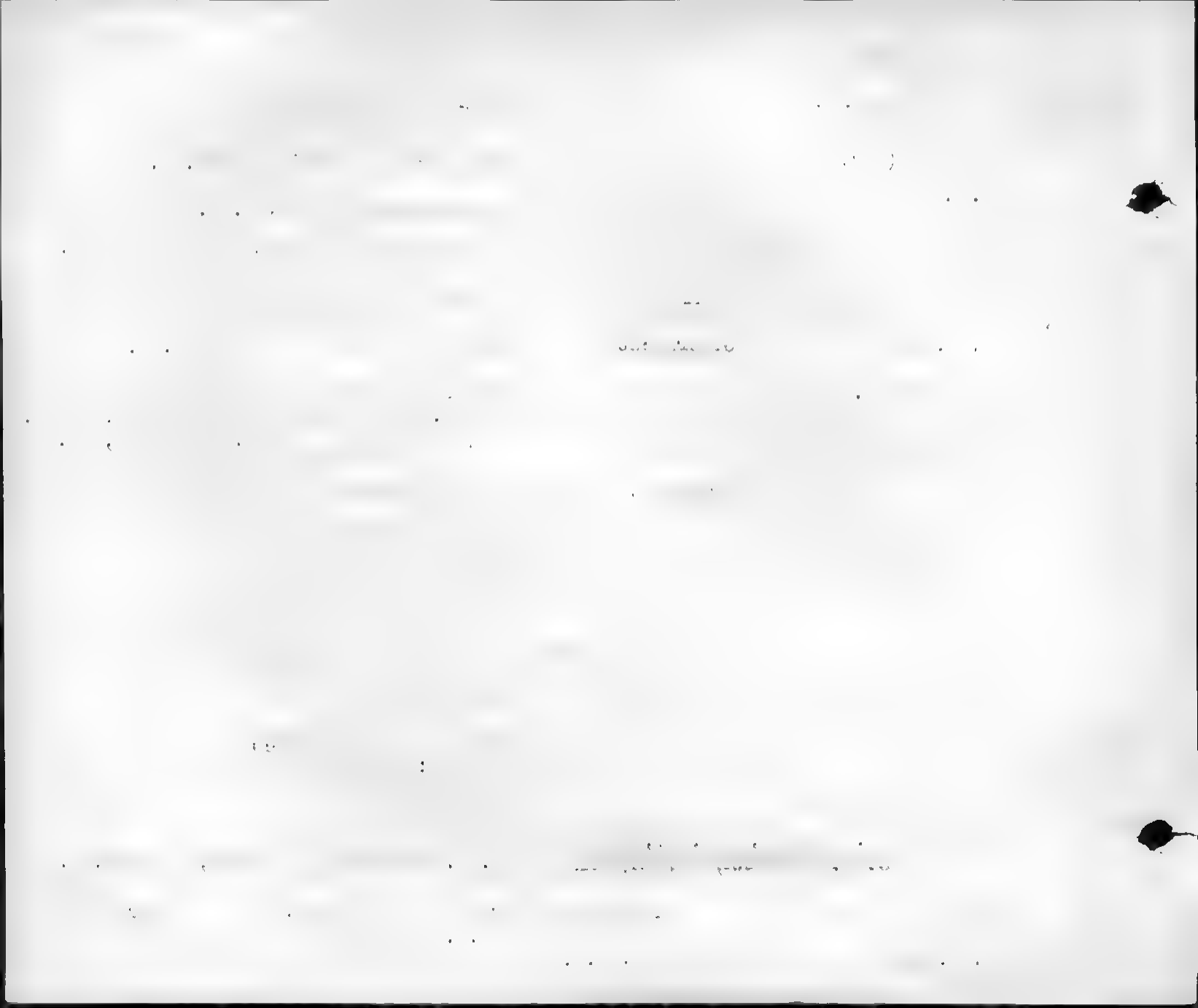
997

998

999

1000

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) b. STATE District of Columbia COUNTY 4003	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase, Washington, D. C.	
c. LENGTH OF STAY IN 1b 59 Days		d. STREET ADDRESS 3389 Stephenson Place, N. W.	
d. NAME OF HOSPITAL (If not in hospital, give street address) U.S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First THOMAS Middle ELMS Last ORR		4. DATE OF DEATH Month OCTOBER Day 2 Year 1960	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-23-1883
9. AGE (In years lost birthday) 77 yrs		10. IF UNDER 1 YEAR Months 77 Days 77 Hours 77 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. NAVY		10b. KIND OF BUSINESS OR INDUSTRY Government	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Jefferson D. ORR		14. MOTHER'S MAIDEN NAME Margaret Elizabeth BRITTEN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWI		16. SOCIAL SECURITY NO	
17. INFORMANT Mrs. Walter MOORE (Sister)		Address 606 20th. St. S. So. ARLINGTON, Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, prostate with metastasis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 177X DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 4 mos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 4, 1960 to October 2, 1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 2, 1960 , and that death occurred at 3:35 PM , from the causes and on the date stated above.			
22a. SIGNATURE H. Hubbard		22b. DATE SIGNED 10-3-60	
22c. PHYSICIAN'S NAME (Type) H. HUBBARD, CDR, MC, USN		22d. ADDRESS U. S. Naval Hospital, NNMC, Bethesda, Md.	
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10-5-60	23c. NAME OF CEMETERY OR CREMATORY Arlington Cemetery	23d. LOCATION (City, town, or county) (State) Arlington, Virginia
24. FUNERAL DIRECTOR'S SIGNATURE S. H. HINES		25a. REC'D BY REGISTRAR DATE OCT 5 '60	
ADDRESS 2901 14th St., N.W.		25b. REGISTRAR'S SIGNATURE Arthur L. Hines	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

Dr. Brochardt notified

1

11635

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11596

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>DOA</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Rosa</u> Middle <u>Louise</u> Last <u>Pagano</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>2</u> Year <u>1960</u>			
5. SEX <u>f</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 26, 1883</u>	9. AGE (In years last birthday) <u>77</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Dominico Bertana</u>				14. MOTHER'S MAIDEN NAME <u>Silvana Odone</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>Unknown</u>		17. INFORMANT <u>Albert G. Crosetto</u> Address <u>4700 B-ttery L a. Bethesda</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> <u>53.9.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (c): (b) <u>Hypertension, anemia, arthritis</u> (c) <u>Dysrhythmia, myocardial + peripheral vascular disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>as above</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>—</u> p. m. <u>—</u> 19 <u>60</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>July 1955</u> to <u>Oct 2, 1960</u> , that (I) <u>was</u> last saw the deceased alive on <u>Oct 1, 1960</u> , and that death occurred at <u>5:06 PM</u> , from the causes and on the date stated above							
22a. SIGNATURE <u>Margaret E. Callan MD</u>				22b. DATE <u>Oct 2, 1960</u>			
22c. PHYSICIAN'S NAME (Type) <u>Margaret E. Callan</u>				22d. ADDRESS <u>4700 - Bradley Blvd. Ch. Ch. 15, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/5/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>West Hill Cemetery</u>		23d. LOCATION (City town or county) (State) <u>Galeton, Pennsylvania</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				25a. REC'D BY REGISTRAR <u>OCT 5 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Finner</u>	



CERTIFICATE OF DEATH

Reg. Dist. No. 11597

11538

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tokoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> <u>164</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Sant. Hospital</u>				d. STREET ADDRESS <u>3210 Chillum Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Effie</u> Middle <u>Jane</u> Last <u>Paine</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>18</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 6 1871</u>	9. AGE (In years last birthday) <u>88</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Dice</u>				14. MOTHER'S MAIDEN NAME <u>Mary Taylor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT Address <u>Dorathy M. Pain 3210 Chillum Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral accident.</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 1959</u> to <u>Oct. 1960</u> that I last saw the deceased alive on <u>10/17/60</u> and that death occurred at <u>9:30 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4700-16 St. N.W.</u> DATE SIGNED <u>10/19/60</u>							
ACTUAL SIGNATURE <u>Stephen F. Verges</u> M.D.				PHYSICIAN'S NAME (Type) <u>Stephen F. Verges</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-21-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Real Funeral Home</u>				ADDRESS <u>4812 Ga. Ave. N.W.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 21 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraw</u>			

TO HOSPITAL: 2. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11636

11598

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>6231 Rockhurst Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Lena</u> Middle <u>Rose</u> Last <u>Pearlin</u>				4. DATE OF DEATH Month <u>10</u> Day <u>20</u> Year <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/14/89</u>	9. AGE (In years last birthday) <u>71</u> yrs	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Latvia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Joseph Marienberg</u>			
14. MOTHER'S MAIDEN NAME <u>Betta Bravin</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>			
16. SOCIAL SECURITY NO <u>—</u>				17. INFORMANT <u>Leonard Pearlman, same as above</u> Address <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction acute</u> DUE TO <u>Coronary insufficiency</u> (b) <u>Coronary arteriosclerosis</u> (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (the hospital) attended the deceased from <u>Nov. 1957</u> to <u>Oct 20, 1960</u> , that (I) (we) last saw the deceased alive on <u>Oct. 20 1960</u> , and that death occurred at <u>10:23</u> M, from the causes and on the date stated above							
22a. SIGNATURE <u>Alfred S. Norton</u>				22b. DATE SIGNED <u>Oct 20, 1960</u>			
22c. PHYSICIAN'S NAME (Type) <u>DR. Alfred S. NORTON, M.D.</u>				22d. ADDRESS <u>4711 - Highland Ave - Beth. Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>CREMATION</u>		<u>10-21-60</u>		<u>CEDAR HILL CREMATORY</u>		<u>SUITLAND - MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>B. Kargansky</u>				25a. REC'D BY REGISTRAR <u>3501-14</u>			
25b. REGISTRAR'S SIGNATURE <u>—</u>				DATE <u>OCT 24 '60</u>			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health for or to burial, cremation, or removal, and in any event, within 72 hours after death.



11637

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

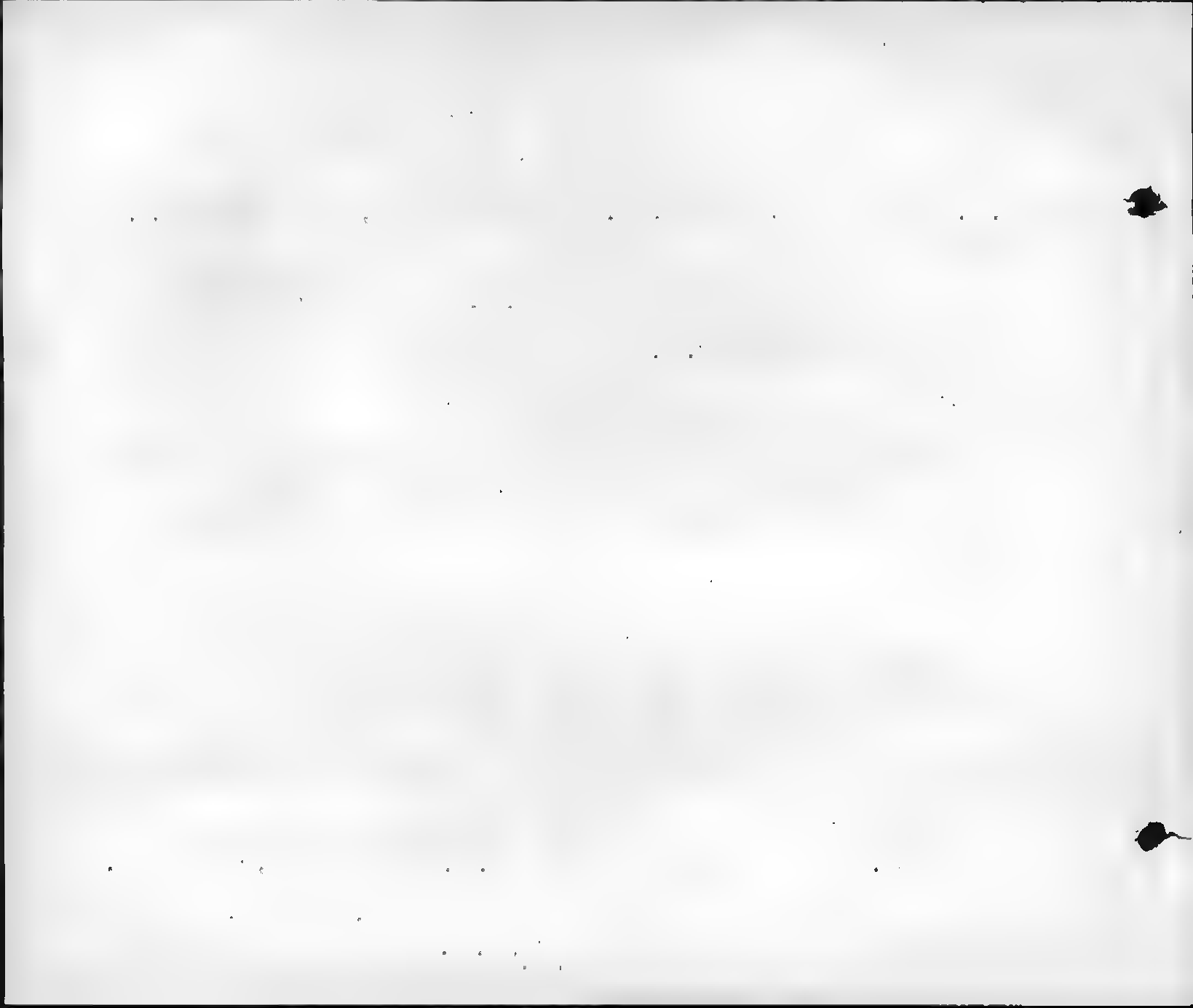
11599

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE District of Columbia b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 3002 Rodman St., NW, Washington D.C.	
3. NAME OF DECEASED (Type or print) Caleb Claybourne Petrey		4. DATE OF DEATH October 23 1960	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-28-90
9. AGE (In years last birthday) 70 yrs		10. IF UNDER 1 YEAR, IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ICDR (MSC) USN RET		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy	
11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Grant Petrey		14. MOTHER'S MAIDEN NAME Nancy Siler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) as WW1 & WW2		16. SOCIAL SECURITY NO. 228-34-7226	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: 443 X IMMEDIATE CAUSE (a) Infection multiple, 17 leg, spinal, RT kidney, Tuberculosis heart Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Atherosclerosis + Hypertension + secondary cardiac DUE TO (c) Aortic stenosis PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Aortic stenosis			
INTERVAL BETWEEN ONSET AND DEATH 4-3 weeks			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from 3 October 1960 to 23 October 1960 , that (X) (we) last saw the deceased alive on 23 October 1960 , and that death occurred at 5:55 AM , from the causes and on the date stated above.			
22a. SIGNATURE M. W. VOSS M.D.		22b. DATE SIGNED 10-23-60	
22c. PHYSICIAN'S NAME (Type) M.W. VOSS ICDR MC USN		22d. ADDRESS U. S. Naval Hospital, Bethesda Md.	
23a. BURIAL, CREMAT OR REMOVAL (Specify) Burial		23b. DATE THEREOF 10-26-60	
23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery, Arlington, Virginia		23d. LOCATION (City town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawlers & Sons		25a. REC'D BY REGISTRAR 1756 Pennsylvania, N. W.	
25b. REGISTRAR'S SIGNATURE Washington, D. C.		DATE OCT 25 '60	

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death.

VR A15 (4)
15M 11/59

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 22 hours after death.



P1551

CERTIFICATE OF DEATH

11600

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. LENGTH OF STAY IN 1b 5 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Asbury Methodist Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
		d. STREET ADDRESS 1339 W. St., S. E.	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Catherine Middle Barbara Last Pieper		4. DATE OF DEATH Month Oct Day 21 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 2, 1881
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeping		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13. FATHER'S NAME Charles A. Pieper		14. MOTHER'S MAIDEN NAME Mary Ellen Pyles	
---	--	---	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. none	INFORMANT Records of Asbury Methodist Home, Gaithersburg, Md.	Address
---	--	---	---------

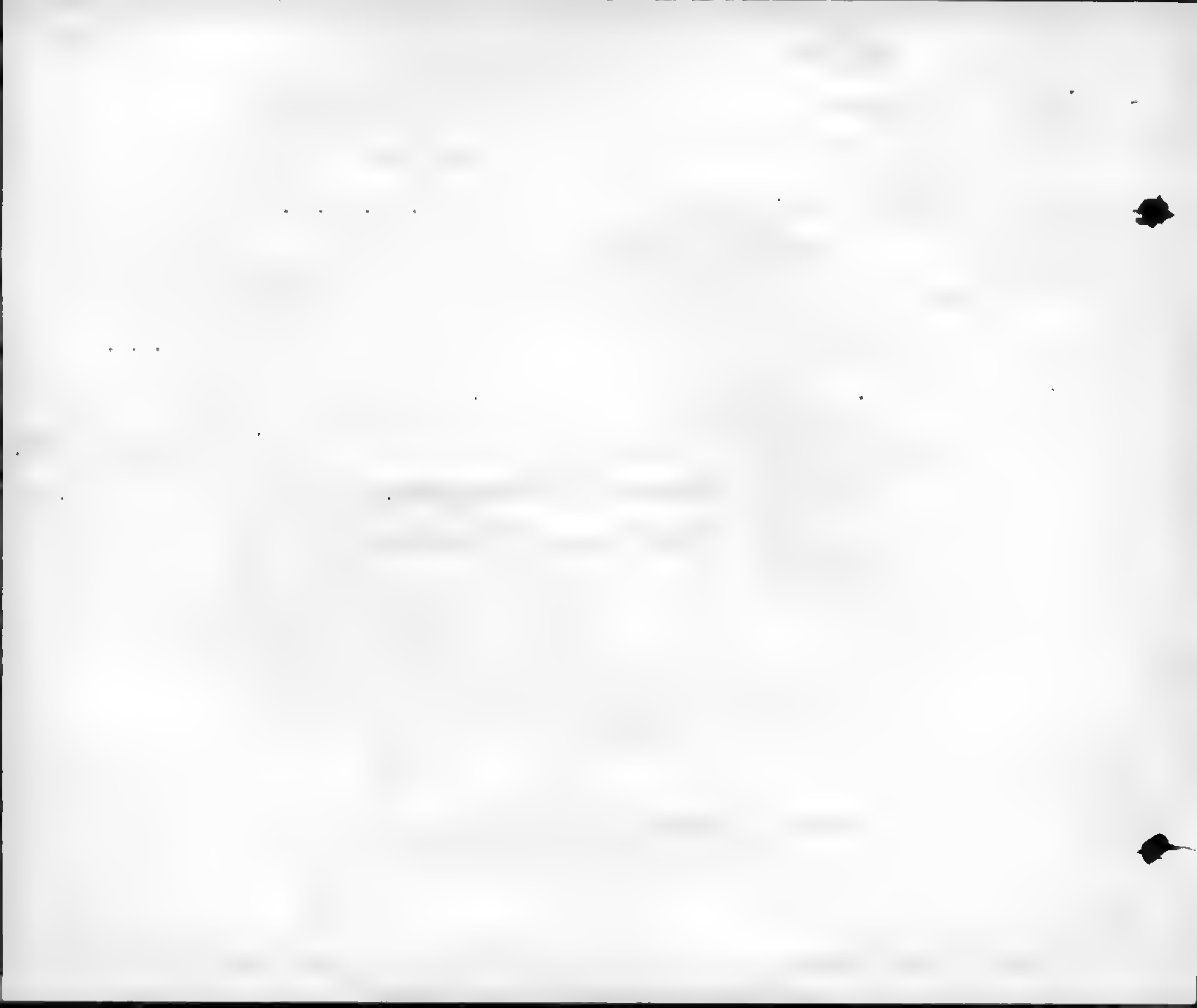
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Vascular Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 days several yrs.
---	--	--

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
--	--	---

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10-16 , 19 60 , to 10-21 , 19 60 that I last saw the deceased alive on 10-20 , 19 60 , and that death occurred at 12-10 PM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 7720 Wisconsin Ave. Bethesda, Md.	DATE SIGNED 10/26/60
ACTUAL SIGNATURE James W. Egan		M.D. 7720 Wisconsin Ave. Bethesda, Md.	
PHYSICIAN'S NAME (Type) JAMES W. EGAN		7720 Wisconsin Bethesda, Md.	

22a. BURIAL, CREMATION, REMOVAL (Specify) Buried Oct 24	22b. DATE THEREOF Oct 24	22c. NAME OF CEMETERY OR CREMATORY Eldar Hill	22d. LOCATION (City, town, or county) (State) South of Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Samuel Buss		ADDRESS 1661 Good Hope Rd S.E. Wash 26, D.C.	24a. REC'D BY REGISTRAR OCT 24 1960
		24b. REGISTRAR'S SIGNATURE Allen S. Kline	



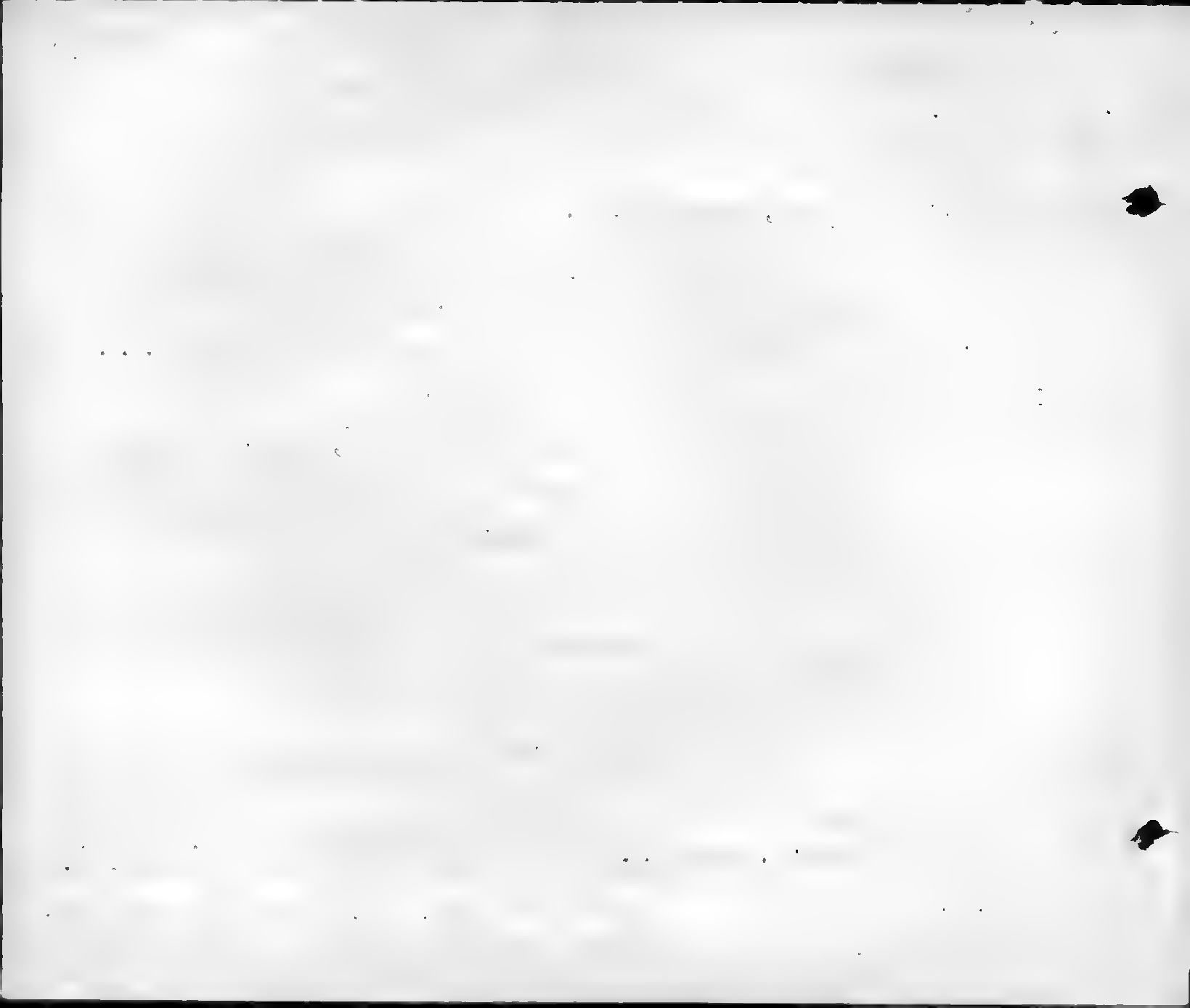
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, on any event within 72 hours after death.

MARYLAND STATE BOARD OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11601

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Pennsylvania ✓ b. COUNTY _____				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 45 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waverly			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS Box 189		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Laura Middle Sayer Last Post				4. DATE OF DEATH Month October Day 7 Year 1960				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 21, 1954		
9. AGE (In years lost birthday) 6 yrs		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS Hours _____ Min. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Jack Post				14. MOTHER'S MAIDEN NAME Ruth Schwartz				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no. or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pseudomonas Septicemia DUE TO Acute Lymphatic Leukemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) _____ DUE TO _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH 4 days 10 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a);							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month _____ Day _____ Year 19 Hour _____ a. m. _____ p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that (I) (this hospital) attended the deceased from August 23, 1960 to October 7, 1960, that (I) (we) last saw the deceased alive on October 7, 1960, and that death occurred at 5:50 PM from the causes and on the date stated above.								
22a. SIGNATURE Edward E. Morse				22b. DATE SIGNED 10/7/60		22c. PHYSICIAN'S NAME (Type) Edward E. Morse, M.D.,		
22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.				22e. M.D. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 10/11/60		23c. NAME OF CEMETERY OR CREMATORY Abington Hills Cem.		23d. LOCATION (City, town, or county) S. Abington Twnshp, Pa. (State) _____		
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				25a. REC'D BY REGISTRAR Bethesda, Maryland		25b. REGISTRAR'S SIGNATURE Arthur L. Frank		



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit form. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISM
SM 7/59

FOR STATE
HEALTH DEPT.

M

1

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
11639 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11602									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg R-1</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg - R-1</u>				
c. LENGTH OF STAY IN 1b					d. STREET ADDRESS <u>Emory Grove Rd</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Emory Grove Rd</u>					4. DATE OF DEATH <u>Oct 29 1960</u>				
5. SEX <u>Female</u>					6. COLOR OR RACE <u>col</u>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>6-2-1909</u>				
9. AGE (in years, last birthday) <u>51</u> yrs.					10. AGE (in years, last birthday) <u>51</u> yrs.				
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>practical nurse</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>				
13. FATHER'S NAME <u>Rock Potts</u>					14. MOTHER'S MAIDEN NAME <u>Effie Petty</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO. <u>INFORMANT</u>				
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fragmentation of brain</u> 981X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>shot gun wound</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot in head with 16 ga. shot gun</u>									
20c. TIME OF INJURY Month, Day, Year <u>10-29-1960</u> Hour <u>1:00</u> p.m.									
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input checked="" type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>									
20f. (City or town) <u>Gaithersburg</u> (County) <u>Montg</u> (State) <u>md</u>									
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>									
CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
DATE SIGNED <u>10-30-60</u>									
Address (Street, city, town, or county)									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>									
22b. DATE THEREOF <u>11/3/60</u>									
22c. NAME OF CEMETERY OR CREMATORY <u>Emory Grove.</u>									
22d. LOCATION (City, town, or country) (State) <u>Gaithersburg, Md.</u>									
23. FUNERAL DIRECTOR <u>Robert L. Snowden</u> ADDRESS <u>Rockville, Md.</u>									
24a. REC'D BY REGISTRAR <u>NOV 3 '60</u>									
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kram</u>									



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
 15M 9/59

1
 11640
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

11603

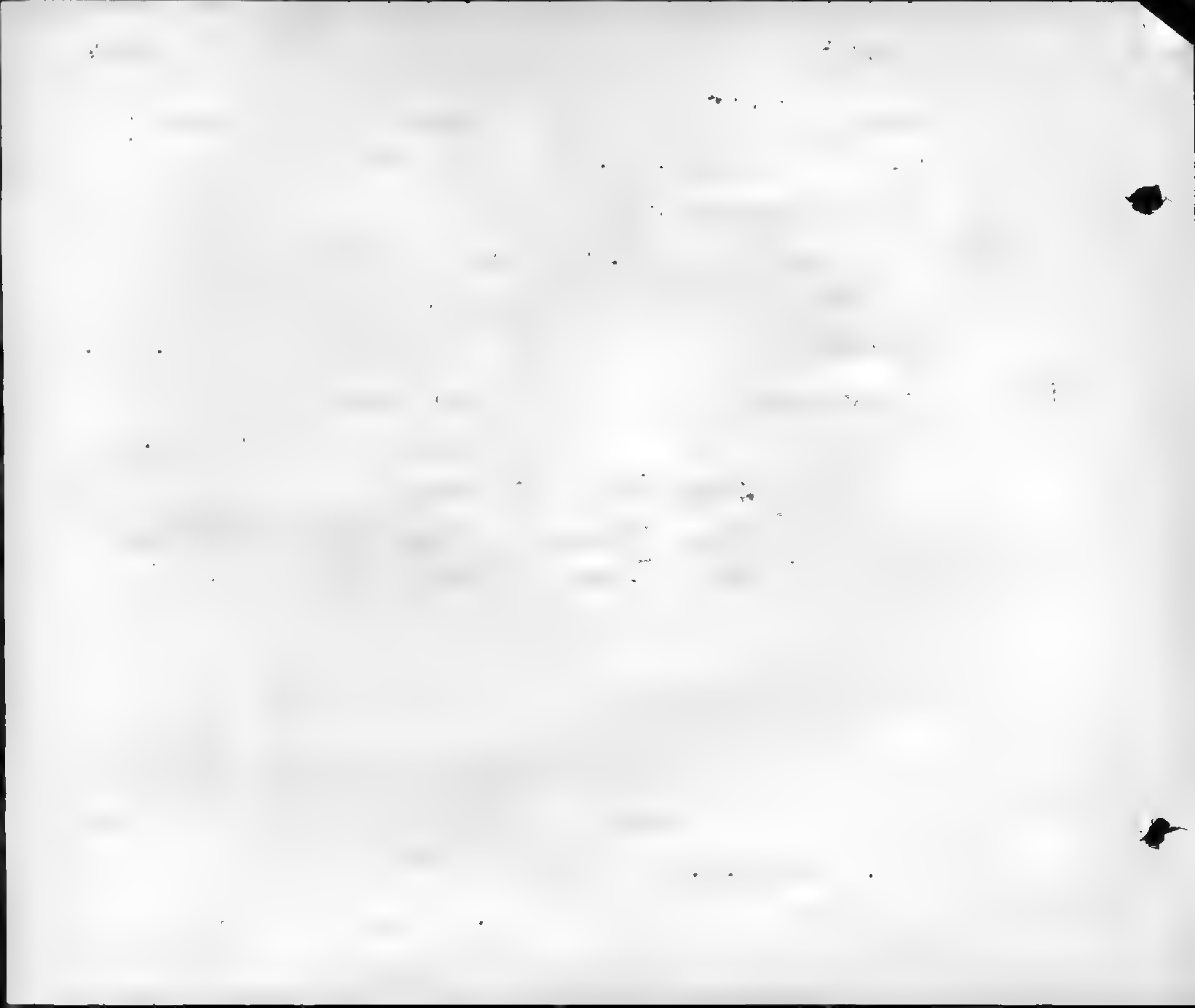
1 PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admrsion) a. STATE <i>DC</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Olney</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Brooke Grove Foundation</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i> 47X	
f. STREET ADDRESS <i>3130 Wisconsin Ave NW</i>		IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <i>Charles DeVault Prather</i>		4. DATE OF DEATH <i>Oct. 1 - 1960</i>	
5 SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <i>Mar. 5-1880</i>
9 AGE (In years last birthday) <i>73</i> yrs		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Hotel Mgr.</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <i>W. Va. - Mo. Carolina</i>		12 CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Joseph Wesley Prather</i>		14. MOTHER'S MAIDEN NAME <i>Julia DeVault</i>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>Yes 9/18/17-WW1</i>		16. SOCIAL SECURITY NO. <i>227-204811</i>	
17. INFORMANT <i>Hosp. Record</i>		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>154X Bronchopneumonia</i> DUE TO (b) <i>Carcinoma of Rectum with metastases to liver</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes Mellitus (mild)</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>9 mo</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED [Enter nature of injury in Part I or Part II of item 18.]	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <i>9-23-</i> <i>1960</i> , to <i>10-1-</i> <i>1960</i> , that (I) (we) last saw the deceased alive on <i>9/30/60</i> , and that death occurred at <i>3:30</i> P. M. from the causes and on the date stated above.			
22a. SIGNATURE <i>C.H. Light</i>		22b. DATE SIGNED <i>10/1/60</i>	
22c. PHYSICIAN'S NAME (Type) <i>C.H. Light</i>		22d. ADDRESS <i>Sandy Spring, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>10/4/60</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Arlington Nat'l. Cem.</i>	23d. LOCATION (City, town, or county) (State) <i>Arlington, Virginia</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>The S. H. Hines Co.</i>		25a. REC'D BY REGISTRAR <i>2901-14th St. NW</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>		DATE <i>OCT 4 '60</i>	



1
 TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11641
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH
 11604

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. LENGTH OF STAY IN 1b 31 HRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL				e. STREET ADDRESS EMORY GROVE		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SAMUEL Middle TODIAS Last PRATHER				4. DATE OF DEATH Month OCTOBER Day 26 Year 1960			
5. SEX MALE		6. COLOR OR RACE NEGRO		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/14/05	
9. AGE (In years last birthday) 55 yrs		10. IF UNDER 1 YEAR Months 55 Days 55 Hours 55 Min		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNEMPLOYED				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME TODIAS PRATHER				14. MOTHER'S MAIDEN NAME EDITH MOORE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) NO				16. SOCIAL SECURITY NO. HOSPITAL RECORDS,		17. INFORMANT OLNEY, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) diabetic Coma DUE TO (b) Necrotizing Papillitis (Kidneys) DUE TO (c) Bilateral Bronchopneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month 10 Day 30 Year 1960 Hour 10 a. m. 30 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home farm, factory, street, office bldg., etc.) GAITHERSBURG, MARYLAND		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/27/60 to 10/27/60 , that (I) (we) last saw the deceased alive on 10/27/60 , and that death occurred at 10/27/60 M, from the causes and on the date stated above							
22a. SIGNATURE L. I. LEAL, M. D.				22b. DATE SIGNED 10/27/60		22c. PHYSICIAN'S NAME (Type) L. I. LEAL, M. D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 10/30/60		23c. NAME OF CEMETERY OR CREMATORY Brooke Grove Cem.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden - Rockville, Md.				25a. REC'D BY REGISTRAR 10/31/60		25b. REGISTRAR'S SIGNATURE William S. Hines	



CERTIFICATE OF DEATH

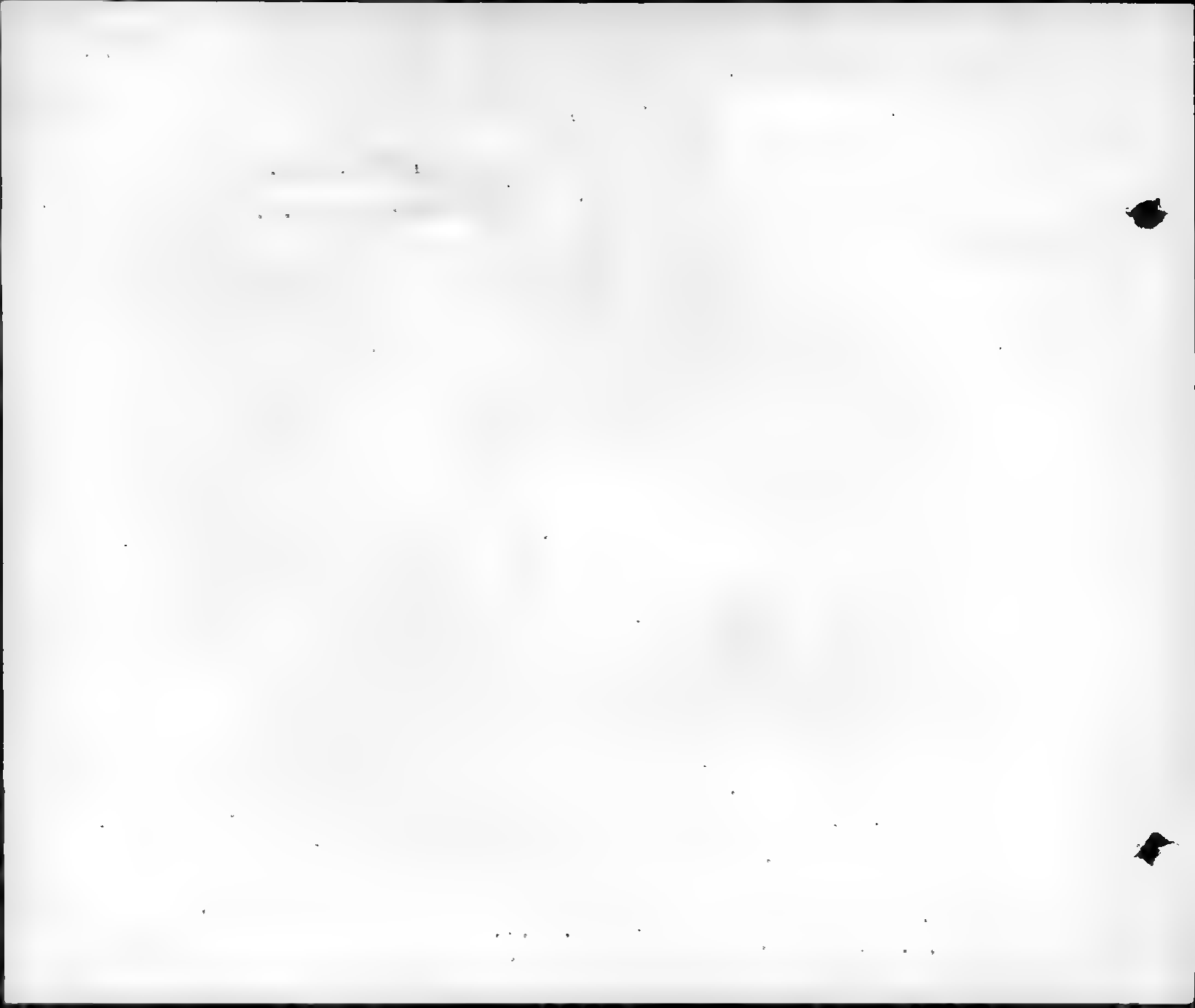
11605
Reg. Dist. No.

11539

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Reside before admission) a. STATE <u>Washington, D.C.</u> b. COUNTY <u>477 X</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>6 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash San Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Harvey</u> Middle <u>Vern</u> Last <u>Prentice</u>				4. DATE OF DEATH Month <u>10</u> Day <u>6</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-16-88</u>	
9. AGE (In years last birthday) <u>72</u> yrs		10. IF UNDER 1 YEAR Months <u>12</u> Days <u>12</u> Hours <u>12</u> Min.		11. BIRTHPLACE (State or foreign country) <u>So. Dakota</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clergyman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Mission work</u>			
13. FATHER'S NAME <u>Gernette Prentice</u>				14. MOTHER'S MAIDEN NAME <u>Ella</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <u>577-48-1596</u>			
17. INFORMANT <u>Hospital Records</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>+20.1</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Heart Disease</u> DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a m</u> <u>19</u> p. m.				20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>9-30</u> , 1960, to <u>10-6</u> , 1960, that I last saw the deceased alive on <u>10-6</u> , 1960, and that death occurred at <u>12:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stuart L. Nelson</u>				ADDRESS (Street, city or town, state) <u>7425 Aspen Courts Takoma Park, Md.</u>			
DATE SIGNED <u>10-6-60</u>							
PHYSICIAN'S NAME (Type) <u>Stuart L. Nelson</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>10/8/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>				24a. REC'D BY REGISTRAR <u>OCT 10 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11642

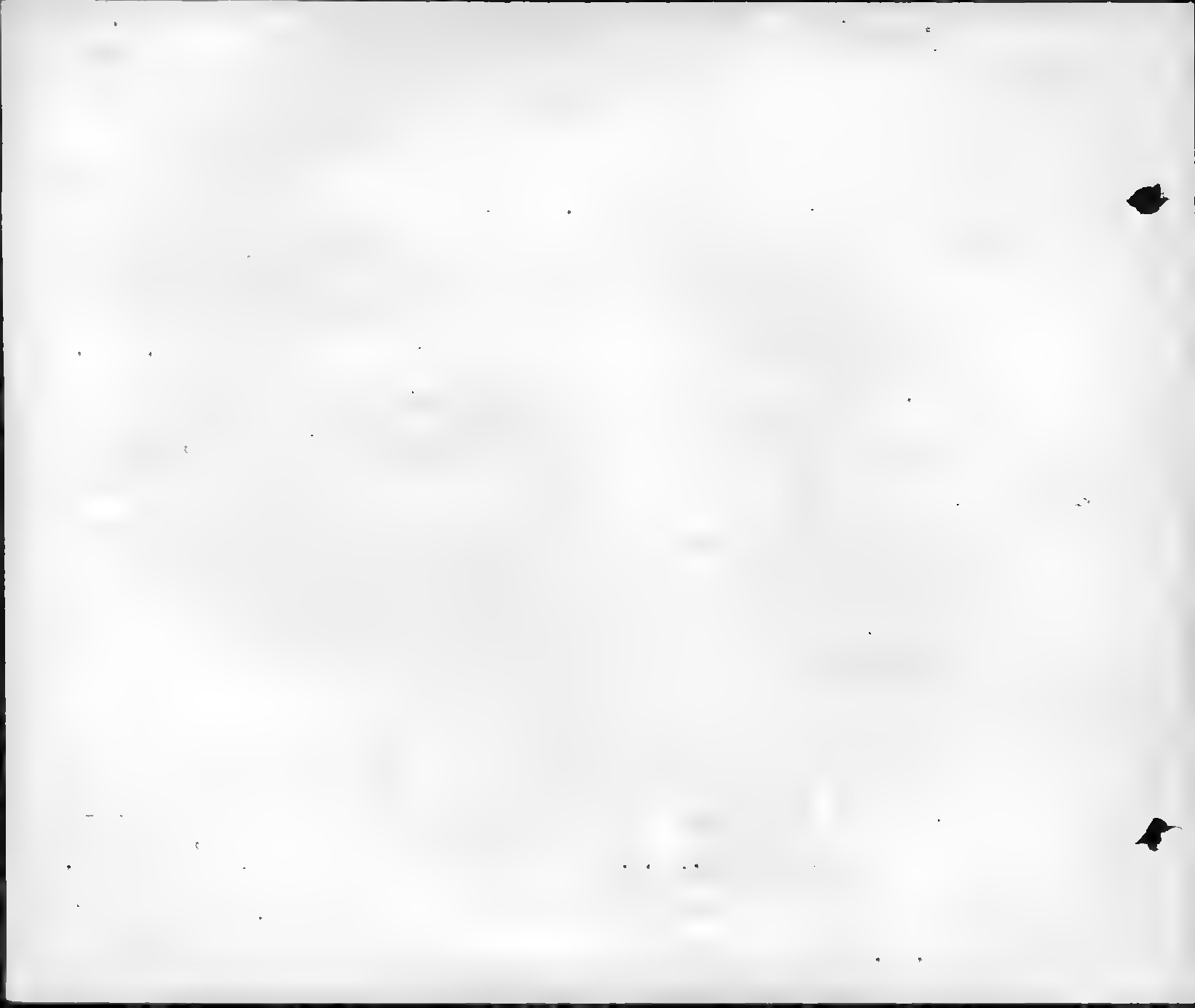
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11606

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE West Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 86 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Bobby Middle Clayton Last Puckett				4. DATE OF DEATH Month October Day 15 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 7, 1957	
9. AGE (In years last birthday) 3		10. IF UNDER 1 YEAR Months 3 Days 15 Hours 15 Min.		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) None (Minor child)				10b. KIND OF BUSINESS OR INDUSTRY None			
13. FATHER'S NAME Ralph E. Puckett				14. MOTHER'S MAIDEN NAME Helen Magyar			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anemia							
DUE TO 193.4 (b) Neuroblastoma							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):							
INTERVAL BETWEEN ONSET AND DEATH 2 Months							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Bluefield, West Virginia				(County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 21 July 19 60 to 15 October 19 60 , that (I) (we) last saw the deceased alive on 15 October 19 60 , and that death occurred on 15 October 19 60 at 5:00am , from the causes and on the date stated above.							
22a. SIGNATURE Vincent H. Bono Jr. M.D.				22b. DATE SIGNED 10-15-60			
22c. PHYSICIAN'S NAME (Type) VINCENT H. BONO, JR., M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
23a. BURIAL, CREMATION REMOVAL (Specify) Removal		23b. DATE THEREOF 10/16/60		23c. NAME OF CEMETERY OR CREMATORY Rose Lawn Gardens		23d. LOCATION (City, town, or county) (State) Bluefield, West Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Company				25a. REC'D BY REGISTRAR DATE OCT 17 '60		25b. REGISTRAR'S SIGNATURE Colbert S. Hines	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and any event within 72 hours after death.

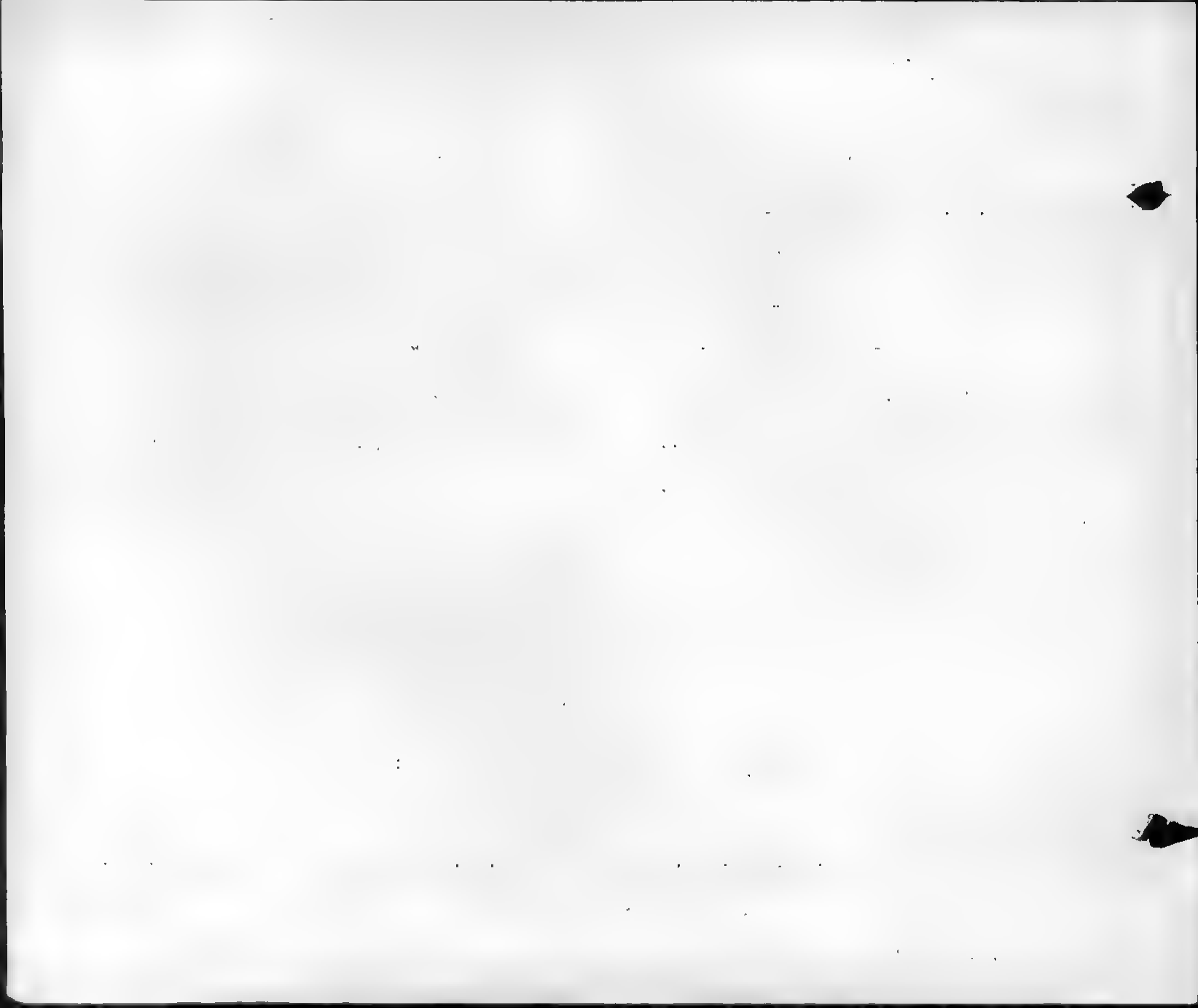


TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

11643										MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										11607									
1. PLACE OF DEATH										2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)																			
a. COUNTY Montgomery					b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)					c. LENGTH OF STAY IN 1b 2 days					a. STATE Maryland					b. COUNTY Charles									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital										d. STREET ADDRESS Idlewood Mobile Manor										e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)										4. DATE OF DEATH																			
First Tracy Middle Lee Last QUINLAN										Month October Day 28 Year 19 60																			
5 SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-26-60		9. AGE (In years last birthday) yrs. 2		IF UNDER 1 YEAR Months 2 Days 2 Hours 2 Min.		IF UNDER 24 HRS. Hours 2 Min.																	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----					10b. KIND OF BUSINESS OR INDUSTRY -----					11. BIRTHPLACE (State or foreign country) Maryland					12. CITIZEN OF WHAT COUNTRY? USA														
13. FATHER'S NAME Lawrence W. QUINLAN										14. MOTHER'S MAIDEN NAME Carol Jean BANCK																			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO None					17. INFORMANT (F) Lawrence W. Quinlan, same as #2 above					Address														
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial hemorrhage 760.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Prematurity										INTERVAL BETWEEN ONSET AND DEATH																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																								
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)														
21. I certify that (I) (do not) attended the deceased from Oct. 26 11:15AM to Oct. 28 1960 , that (I) (was) last saw the deceased alive on Oct. 28 1960 , and that death occurred at M , from the causes and on the date stated above.										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																			
22a. SIGNATURE Fred W. Grello					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED 10-28-60																			
22c. PHYSICIAN'S NAME (Type) Fred W. GRELLO, LT, MC, USN					22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.																								
23a. BURIAL CREMATION, REMOVAL (Specify) Cremation					23b. DATE THEREOF 10-31-60					23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory					23d. LOCATION (City, town, or county) (State) Suitland Maryland														
24. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey										25a. REC'D BY REGISTRAR DATE NOV 1 '60										25b. REGISTRAR'S SIGNATURE Arthur S. Kraus									

2001-1XVI



11540

CERTIFICATE OF DEATH

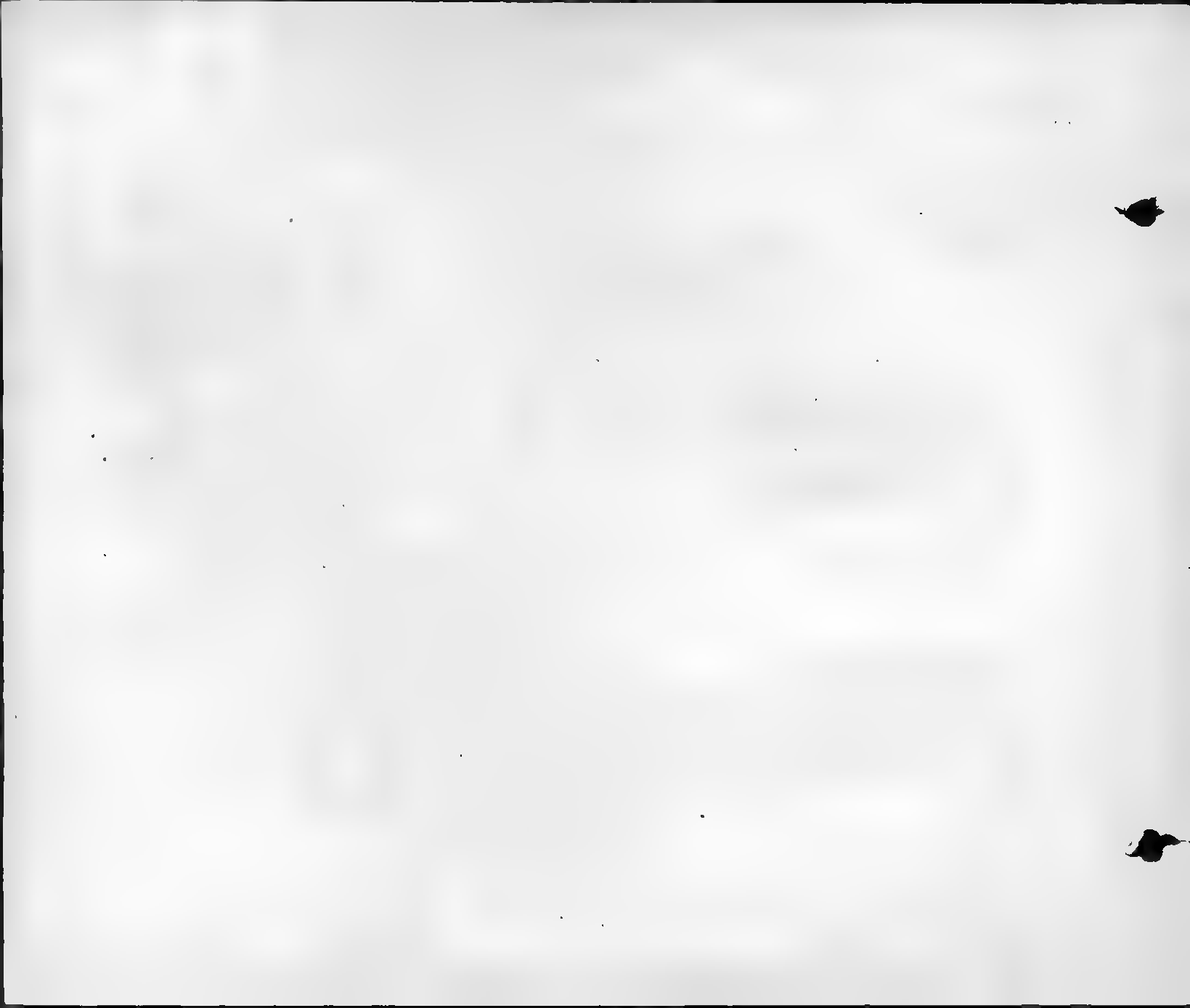
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>BABY-BOY-</u> <u>Reamer</u>		4. DATE OF DEATH Month <u>October</u> Day <u>17</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 15, 1960</u>
9. AGE (In years last birthday) yrs <u>2</u>		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min <u>2</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Leonard Marcus Reamer</u>		14. MOTHER'S MAIDEN NAME <u>Eleanor Holzman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Mother</u>		18. ADDRESS <u>10617 Gatewood Ave. Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>WHITE HEART FAILURE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>TRANSPOSITION OF GREAT VESSELS FROM HEART</u> DUE TO (c) <u>-</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 15, 1960</u> , to <u>October 17, 1960</u> , that I last saw the deceased alive on <u>October 17, 1960</u> , and that death occurred at <u>2:32 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert L. Reichman</u>		ADDRESS (Street, city or town, state) <u>7733 Ashika Drive, Silver Spring, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Robert L. Reichman</u>		DATE SIGNED <u>October 17, 1960</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>burial</u>	<u>10-18-60</u>	<u>North Yeloch</u>	<u>Calto</u> <u>Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewin</u>		24. REC'D BY REGISTRAR DATE <u>OCT 19 '60</u>	
ADDRESS <u>2100 Euteria Pl</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneel</u>	

MEDICAL CERTIFICATION

1

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



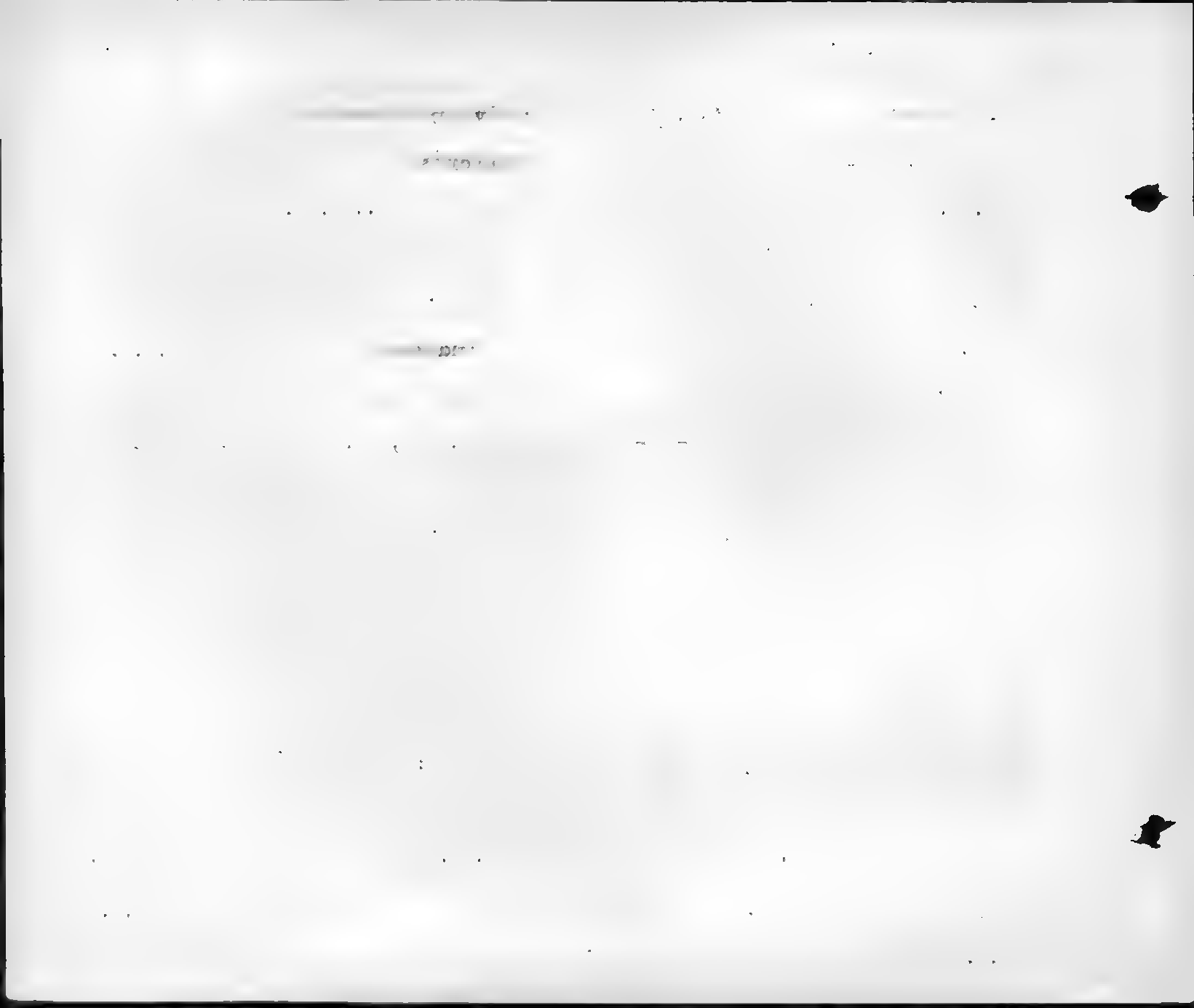
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11609

11644

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN It 166 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		e. STREET ADDRESS Hillcrest Heights 6014 27th Ave.,	
3. NAME OF DECEASED (Type or print) First David Middle Orville Last REASONER		4. DATE OF DEATH Month October Day 8 Year 19 60	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-14-85
9. AGE (In years last birthday) 75 yrs		F UNDER 1 YEAR: Months 75 Days 75 Hours 75 Min. 75	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Artist (Professional)		10b. KIND OF BUSINESS OR INDUSTRY Indiana	
11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward REASONER		14. MOTHER'S MAIDEN NAME Louellen ALLEN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-48-3287 (Soul)	
17. INFORMANT Jos. Leo, Jr., same as #2 above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma hypopharynx			
DUE TO (b) Metastases and general debilitation			
DUE TO (c) _____			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from April 25 19 60 to Oct. 8 19 60 , that (I) (we) last saw the deceased alive on Oct. 8 19 60 , and that death occurred at 1:05 PM from the causes and on the date stated above			
22a. SIGNATURE <i>James E. Hansen</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) James E. Hansen		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/11/60	
23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION (City, town, or county) (State) Washington D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE <i>S.H. Hines</i>		25a. REC'D BY REGISTRAR DATE OCT 11 '60	
25b. REGISTRAR'S SIGNATURE <i>William S. Hines</i>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



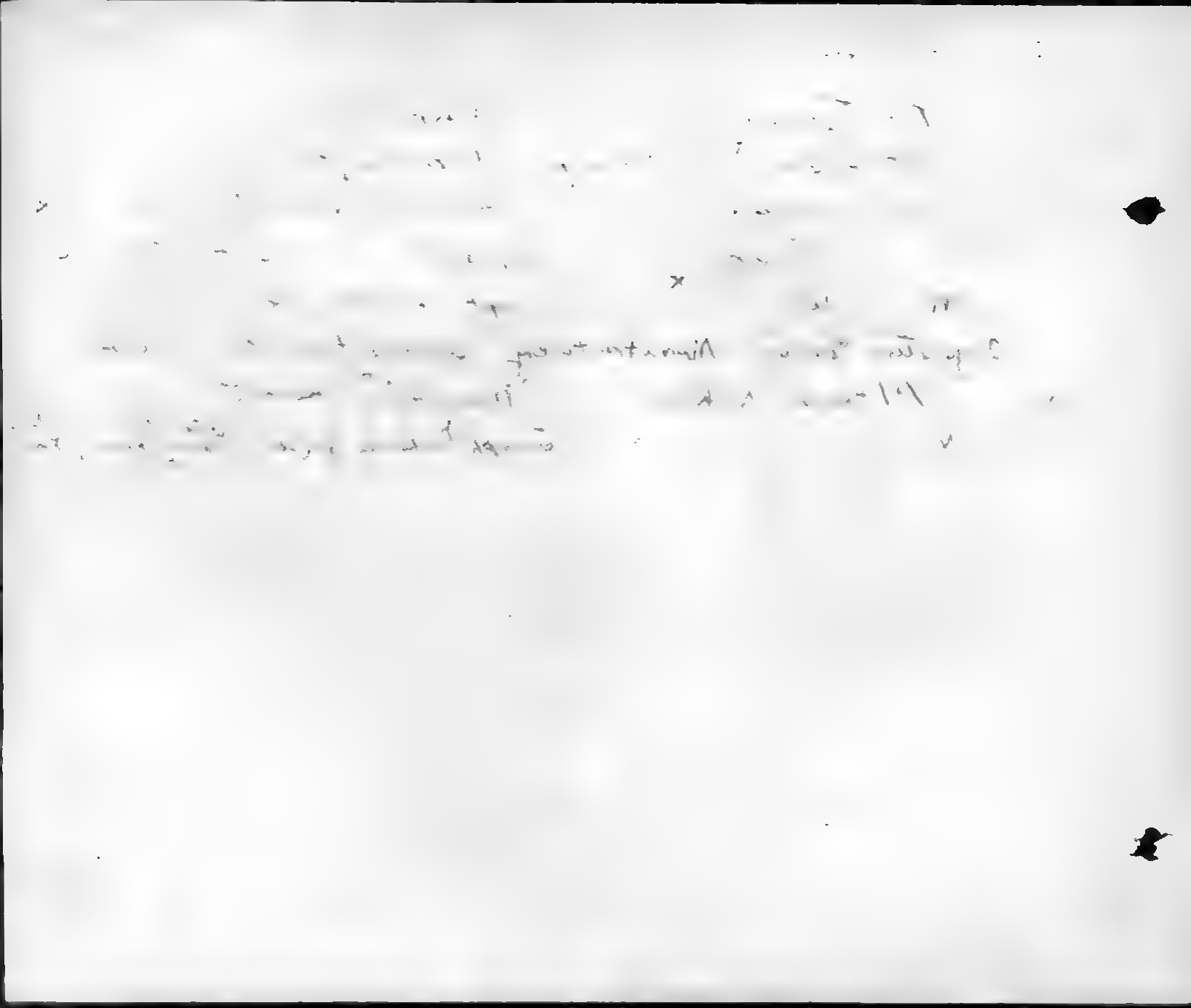
11645

UNITED STATES DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11610

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <i>Wash. D.C.</i> b. COUNTY <i>✓</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>				c. LENGTH OF STAY IN 1b <i>8 1/2 days</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>SUBURBAN</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Joseph</i> Middle <i>Richards</i> Last <i>Richards</i>				4. DATE OF DEATH Month <i>Oct</i> Day <i>30</i> Year <i>1960</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	7. DATE OF BIRTH <i>Sept. 14 1882</i>	9. AGE (In years last birthday) <i>78</i> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cooperation Executive</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Manufacturing</i>		11. BIRTHPLACE (State or foreign country) <i>Washington, DC</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Alfred Richards</i>				MOTHER'S MAIDEN NAME <i>Mary Alice Stewart</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>578015871</i>		17. INFORMANT <i>Joseph Richards Jr (son)</i>		Address <i>6300 Kennedy Dr. Chevy Chase, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>leukemia</i> DUE TO (b) <i>Gastro-intestinal hemorrhage</i> DUE TO (c) <i>ulcer, prepyloric antrum of stomach</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>8 days</i> <i>10 days</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Subtotal gastrectomy; Diabetes mellitus; Arteriosclerosis, generalized</i> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH <i>48 hrs.</i>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>Oct 21, 1960</i> , to <i>Oct 30, 1960</i> , that (I) (we) last saw the deceased alive on <i>Oct 30, 1960</i> , and that death occurred <i>6:30 A.M.</i> from the causes and on the date stated above							
22a. SIGNATURE <i>Robert N. Coale</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>Oct 30, 1960</i>			
22c. PHYSICIAN'S NAME (Type) <i>ROBERT N. COALE</i>		22d. ADDRESS <i>4630 Montgomery Ave. Bethesda, Md.</i>					
23a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>11/2/1960</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven</i>		23d. LOCATION (City, town, or county) (State) <i>Silver Spring, Mont. Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph Richards Sons</i>		ADDRESS <i>1756 Penna Ave NW</i>		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>Charles L. Finner</i>	
				DATE <i>NOV 1 '60</i>			



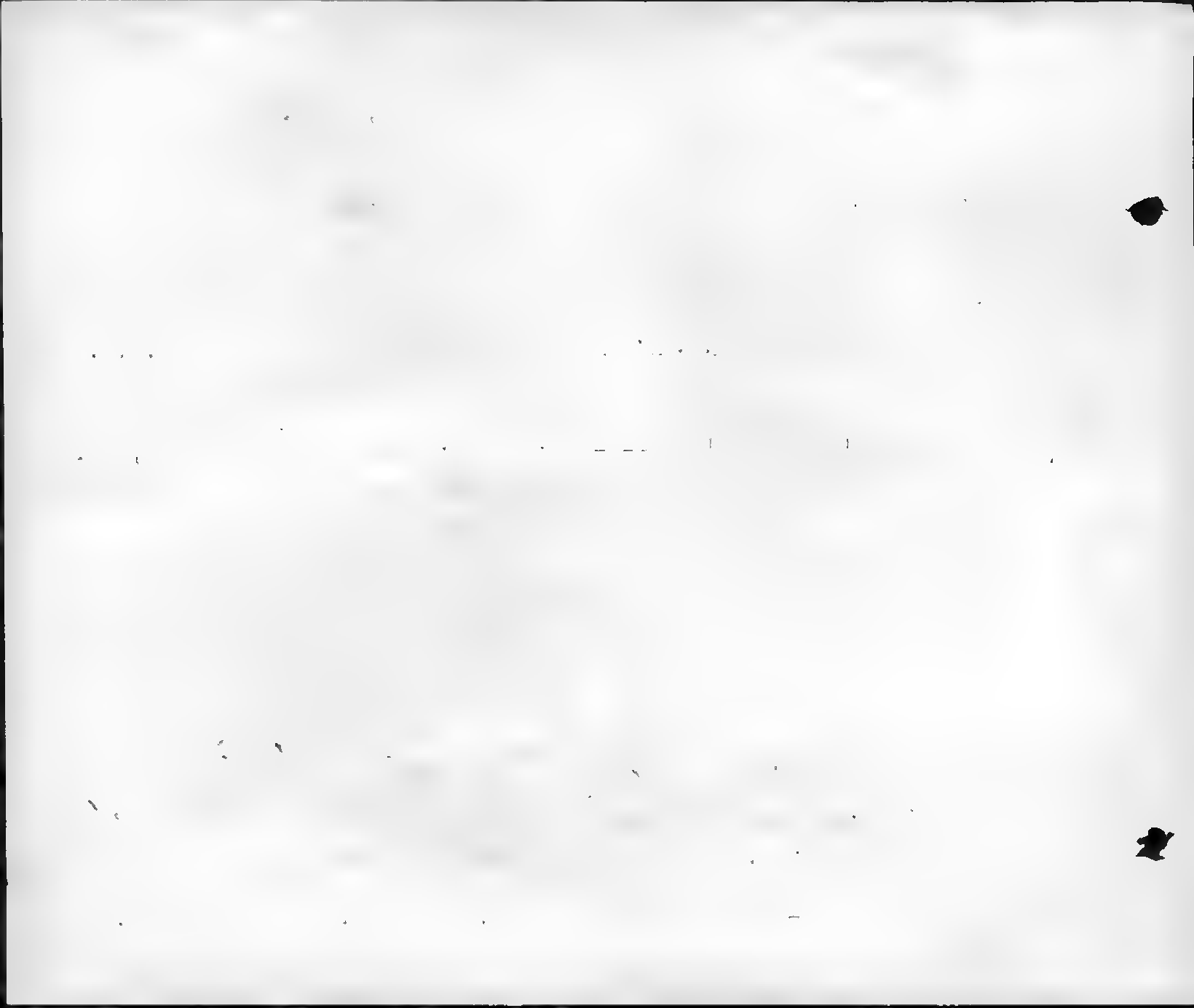
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11549

11611

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Maryland, Mont. b. COUNTY County			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase				c. LENGTH OF STAY IN 1b 55			
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION 4621 Langdrum Lane				d. STREET ADDRESS 4621 Langdrum Lane			
3. NAME OF DECEASED (Type or print) LACEY First F Middle RICKEY Last				4. DATE OF DEATH October 10 1960 Month Day Year			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-27-1890	
9. AGE (In years lost birthday) 70 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Economist		11. BIRTHPLACE (State or foreign country) U.S. Government, Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert Rickey				14. MOTHER'S MAIDEN NAME Margaret Smith			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes				16. SOCIAL SECURITY NO. 7-18 to 11-18		17. INFORMANT Robert F. Richey Address 4621 Langdrum Lane Chevy Chase, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO (b) Instant Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 7-18-9-1936 to Oct-10-1960 that (I) (we) last saw the deceased alive on Oct-7-1960 and that death occurred at 5A M, from the causes and on the date stated above.							
22a. SIGNATURE Bradley D. Hodgkins M.D.				22b. DATE SIGNED Oct 10 '60			
22c. PHYSICIAN'S NAME (Type) BRADLEY D. HODGKINS				22d. ADDRESS 4413 Bradley Lane ChCh Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-13-1960		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cemetery		23d. LOCATION (City, town, or county) (State) Arlington, Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph G. Givens, Inc. 1756-5a Ave. NW Washington 25				25a. REC'D BY REGISTRAR DATE OCT 13 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

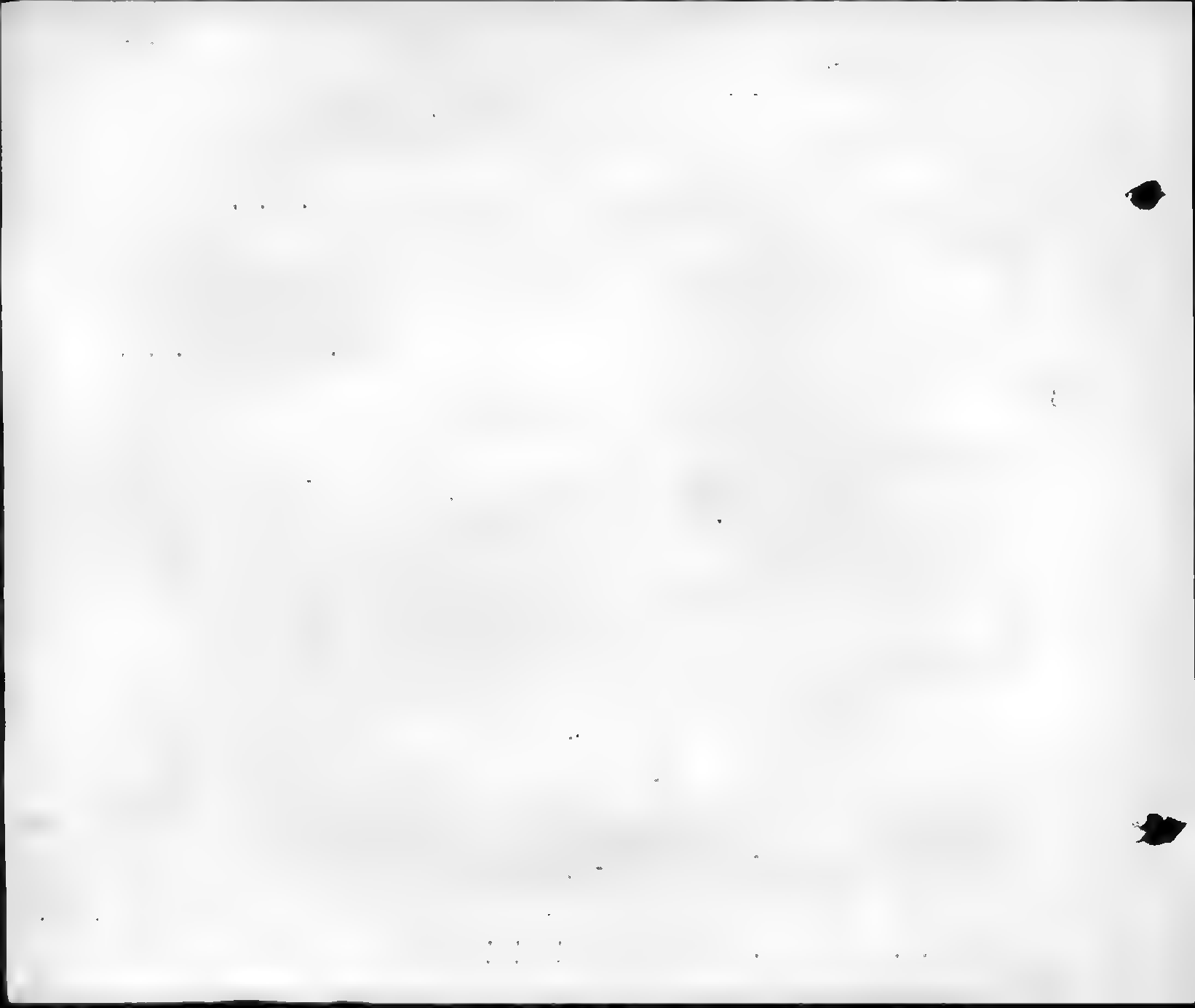
VR AIS (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11612

11646

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wheaton Nursing Home</u>				d. STREET ADDRESS <u>4354 Warren St. N.W.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY ANN RILEY</u>				4. DATE OF DEATH Month Day Year <u>10 19 1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-17-1872</u>	
9. AGE (In years last birthday) <u>88</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Renovo, Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Robert Newton Martin</u>				14. MOTHER'S MAIDEN NAME <u>Anne Pispheon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. E. C. Cash</u> Address <u>4354 Warren St. Wash. D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Heart Disease</u> 743 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Generalized arteriosclerosis</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u> <u>10 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Mar 15 1946</u> to <u>Oct 19 1960</u> that (I) <u>last</u> saw the deceased alive on <u>Oct 16 1960</u> and that death occurred on <u>10/19/60</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Francis P. Hannan</u> M.D.				22b. ADDRESS <u>1511-17 St. N.W. Wash. D.C.</u>		22c. DATE SIGNED <u>Oct. 19, 1960</u>	
22c. PHYSICIAN'S NAME (Type or print) <u>FRANCIS P. HANNAN, M.D.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>10/22/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>				25a. REC'D BY REGISTRAR <u>2901 14th St. N.W. Washington 9, D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>DATE OCT 21 '60</u>	



11647

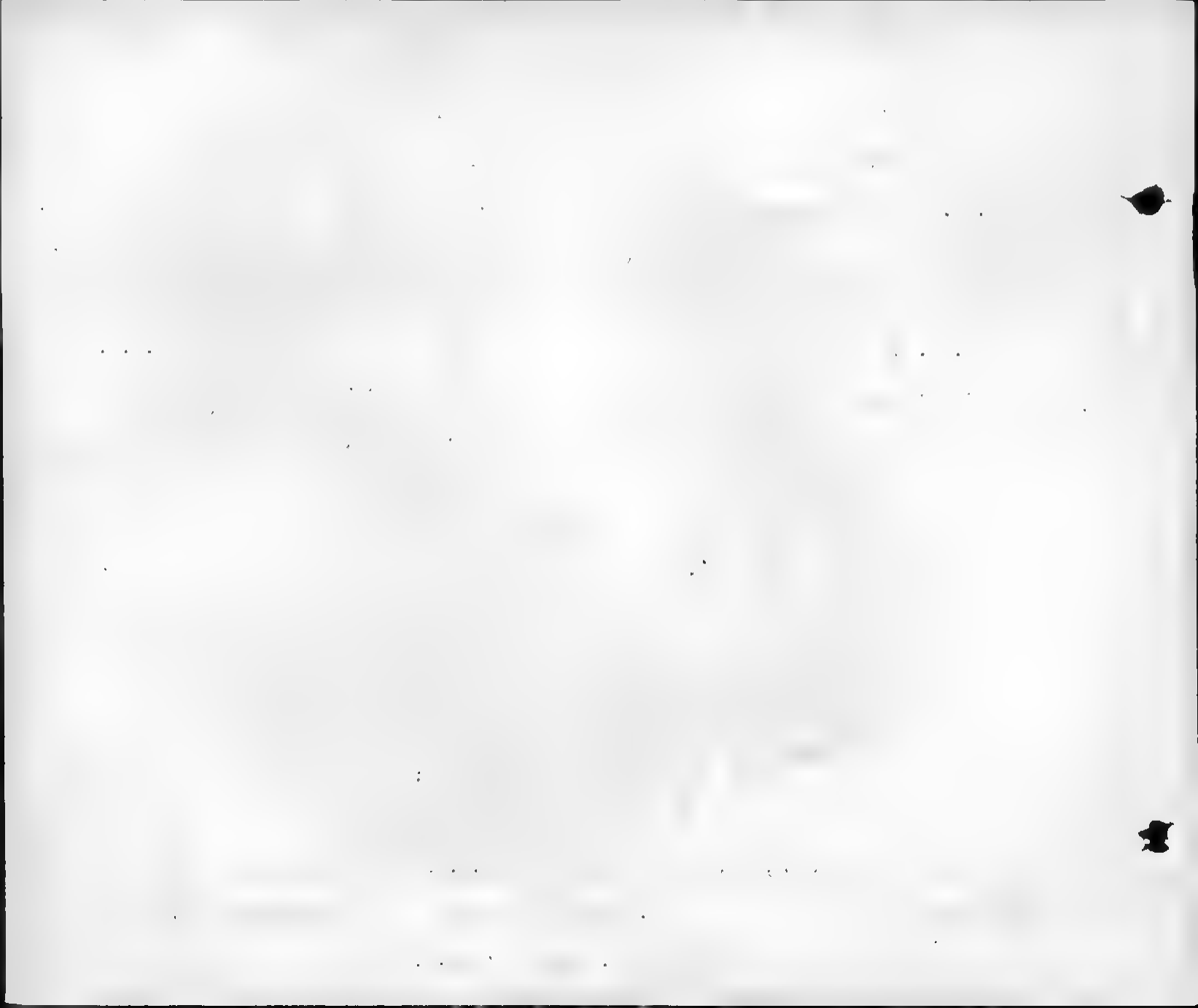
1
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11613

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 1 month d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY 1637-2 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover Hills d. STREET ADDRESS 3906 71st Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First Donald Middle (n) Last RISK		4. DATE OF DEATH Month October Day 29 Year 19 60		5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-20-31		9. AGE (In years last birthday) 29		10. IF UNDER 1 YEAR Months 3 Days 2 Hours 0 Min. 0		11. IF UNDER 24 HRS Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Ohio				12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Samuel RISK								14. MOTHER'S MAIDEN NAME Jennie DIAMOND											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO 424 27 92				17. INFORMANT Mrs. Honor C. RISK, Same as 2d				Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute respiratory insufficiency DUE TO (b) Major pleural effusions DUE TO (c) Hodgkin's disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 201X INTERVAL BETWEEN ONSET AND DEATH 3 weeks 7 years.																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Herpes Zoster, and Varicella n WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month 9 Day 29 Year 19 60 Hour 5:50 AM p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) Washington, D. C. (County) D. C. (State) D. C.							
21. I certify that (I) (the hospital) attended the deceased from 9-29- 19 60 to 10-29- 19 60 , that (I) (we) last saw the deceased alive on 10-29- 19 60 , and that death occurred at 5:50 AM from the causes and on the date stated above.																			
22a. SIGNATURE Russel Miller, Jr. MD								22b. DATE SIGNED 10-29-60				22c. PHYSICIAN'S NAME (Type) Russel Miller, Jr. MD, USN				22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal				23b. DATE THEREOF 10-31-60				23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery				23d. LOCATION (City, town, or county) Washington, D. C. (State) D. C.							
24. FUNERAL DIRECTOR'S SIGNATURE Goldberg Funeral Home								25a. REC'D BY REGISTRAR NOV 1 '60				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1, 2, and 3 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

11048

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11614

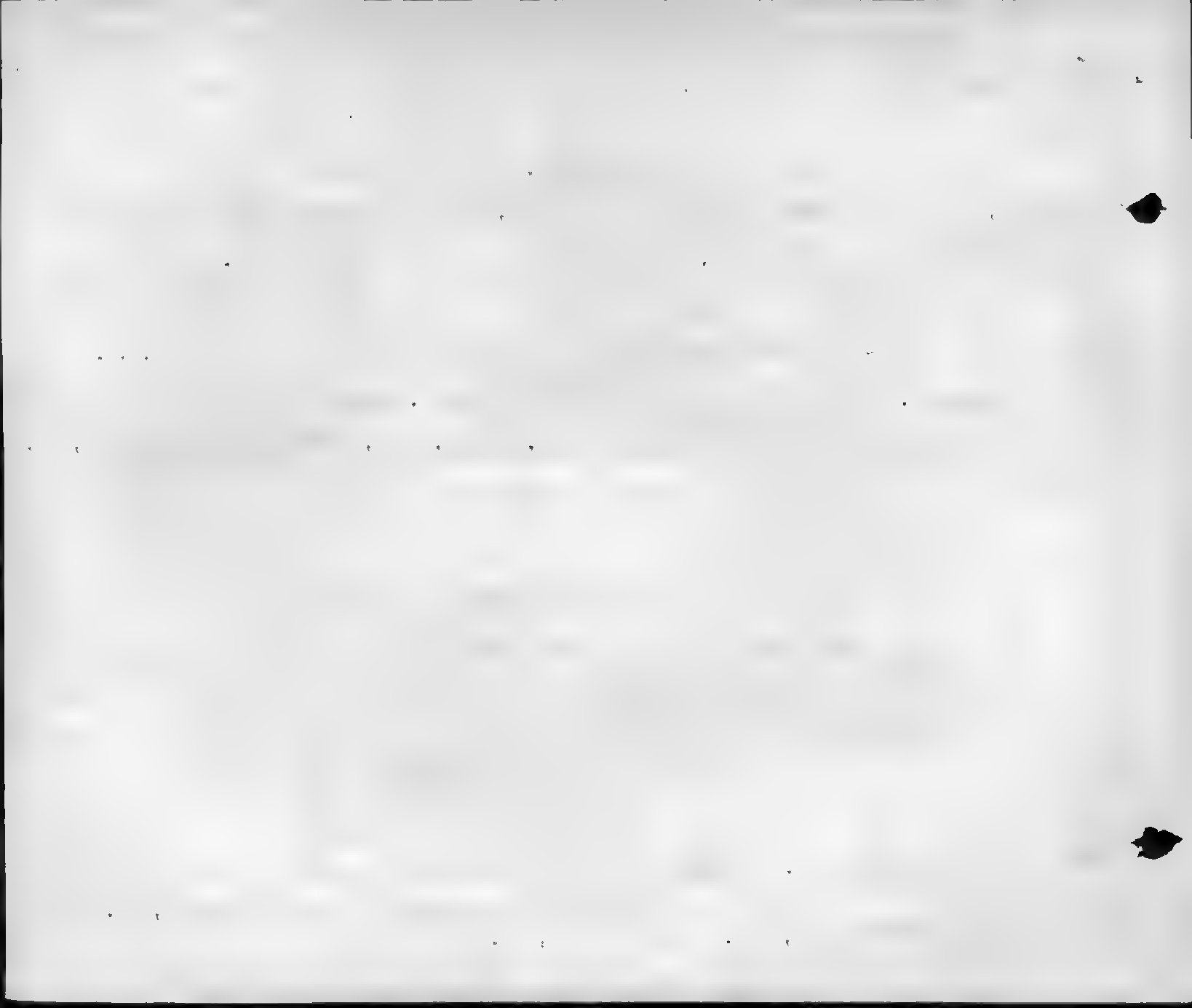
1. PLACE OF DEATH e. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FAIRLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 13,420 COLUMBIA PIKE ROAD				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FAIRLAND d. STREET ADDRESS 13,420 COLUMBIA PIKE ROAD			
3. NAME OF DECEASED (Type or print) ODORION W. ROBY				4. DATE OF DEATH OCT. 6 19 60			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/6/74	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Politician - Ex County Commissioner				10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 86	
11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME THOMAS J. ROBY				14. MOTHER'S MAIDEN NAME HARRIET E. MARLOW			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mrs. Dena A. Roby, Columbia Pike, Fairland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last, (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Frank J. Broschart				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) FRANK J. BROSCHART				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 10/9/60			
22c. NAME OF CEMETERY OR CREMATORY BURTONSVILLE UNION CEMETERY				22d. LOCATION (City, town, or country) (State) MONTGOMERY COUNTY, MD.			
23. FUNERAL DIRECTOR WARNER E. PUMPHREY, INC.				24a. REC'D BY REGISTRAR DATE OCT 11 '60			
ADDRESS SILVER SPRING, MD.				24b. REG. STRAR'S SIGNATURE Arthur S. Frank			

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH **sudden**

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

DATE SIGNED **10/6/60**



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

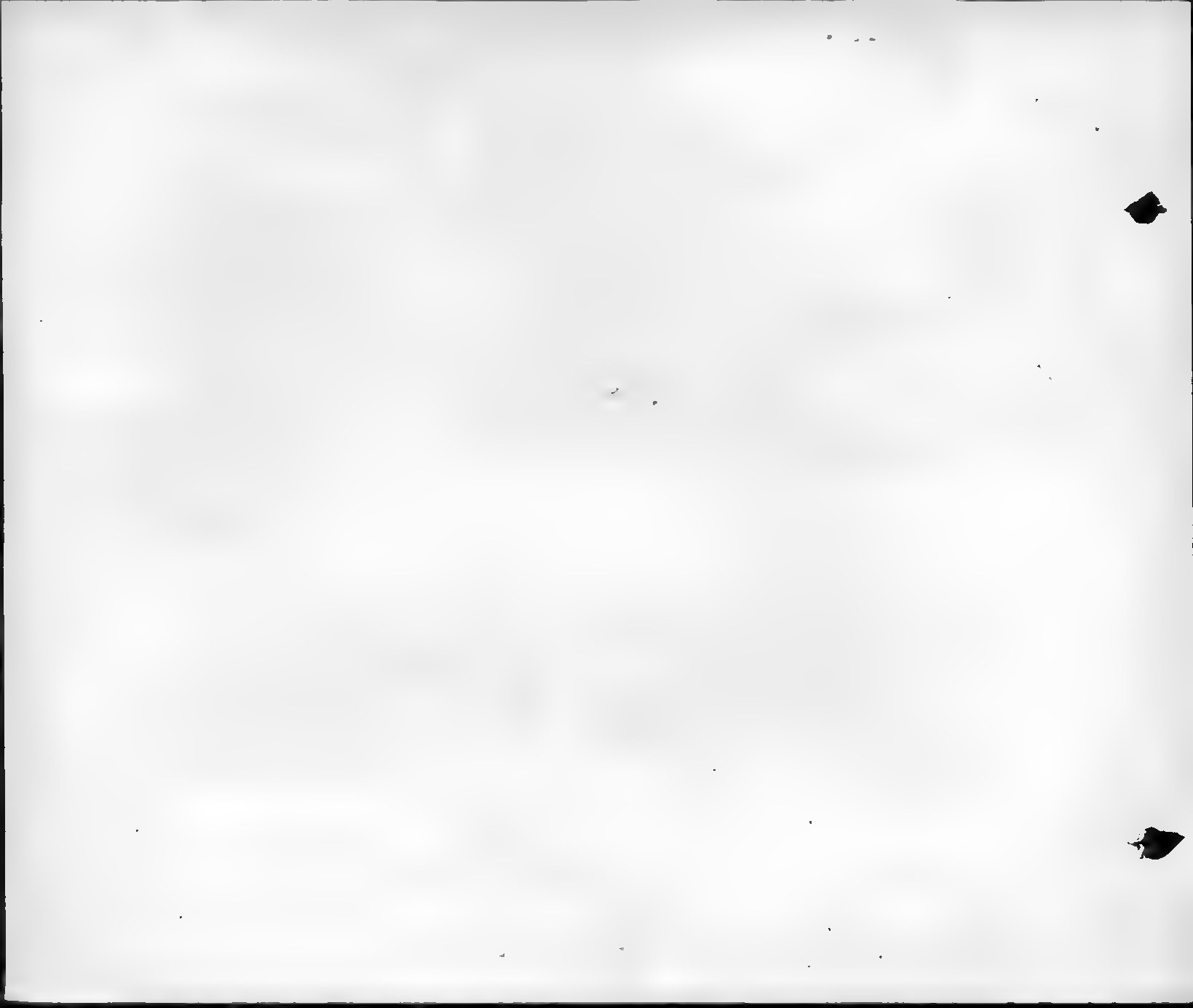
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11555

11615

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington, Md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens San.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Rev. William Oscar Roome</u>				4. DATE OF DEATH Month Day Year <u>Oct. 2 1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 11, 1876</u>	9. AGE (In years last birthday) <u>83</u> yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minister</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Alex. Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm. Oscar Roome, SR.</u>				14. MOTHER'S MAIDEN NAME <u>Margaret COVERT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>Unknown</u>		17. INFORMANT Address <u>Mrs. Harry P. Lowe 10201 - Boston Rd Potomac, Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Circulation shock</u> DUE TO (b) <u>Acute Pyelonephritis and Bronchopneumonia</u> DUE TO (c) <u>Inter-aural Hematoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						INTERVAL BETWEEN ONSET AND DEATH <u>24 hr</u> <u>6 weeks</u> <u>6 m</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 1959</u> to <u>Oct 2, 1960</u> , that (I) (we) last saw the deceased alive on <u>Oct 2</u> 19 <u>60</u> , and that death occurred at <u>ADM</u> from the causes and on the date stated above							
22a. SIGNATURE <u>William H. Kelly</u>				22b. DATE SIGNED <u>10/2/60</u>			
22c. PHYSICIAN'S NAME (Type) <u>W H Kelly</u>				22d. ADDRESS <u>10872 Jells Rd Potomac</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/5/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u> ADDRESS <u>Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 5 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
1
1

11649

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11616

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 45 Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9914 Ashburton Lane				d. STREET ADDRESS 1 9914 Ashburton Lane			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First CATHERINE Middle ABBLETT Last HUMBALL				4. DATE OF DEATH Month Sept. Day 27 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 23 Sept. 1881	
9. AGE (In years last birthday) 79 yrs		IF UNDER 1 YEAR Months 7 Days 27 Hours 15 Min 00		IF UNDER 24 HRS Hours 15 Min 00			
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John William Abblett				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 084-6814		17. INFORMANT John M. Rumball Same As #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA DUE TO LEFT VENTRICULAR FAILURE Conditions, if any which gave rise to immediate cause (b), stating the underlying cause (c), stating the cause last. DUE TO HYPERTENSIVE CARDIOVASCULAR DISEASE INTERVAL BETWEEN ONSET AND DEATH 30 MIN 3 DAYS 15 YRS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CEREBRAL THROMBOSIS - JUNE 10, 1960				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 8:30 p. m. OCTOBER 29, 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from OCT 26, 1960 to OCT 29, 1960 that (I) (we) last saw the deceased alive on OCT 26, 1960 , and that death occurred at 8:30 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Thomas F. O'Connor				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED OCT 27, 1960	
22c. PHYSICIAN'S NAME (Type) THOMAS F. O'CONNOR, M.D.				22d. ADDRESS 4861 BATTERY LANE BETHESDA 14, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 10-31-60		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION (City, town, or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home 300-4th St. N.E. Wash. D.C.				25a. REC'D BY REGISTRAR DATE NOV 1 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kincaid	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove page 3 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
11650					11617				
1. PLACE OF DEATH a. COUNTY Montgomery					2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Florida b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY IN 1b 26 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jacksonville 5				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital					d. STREET ADDRESS 3309 B Gibbs St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Gerald Middle Mc Last SAMPLE, JR.			4. DATE OF DEATH Month October Day 11 Year 19 60						
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-1-60		9. AGE (In years last birthday) yrs 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Gerald Mc SAMPLE					14. MOTHER'S MAIDEN NAME UNKNOWN				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hydrocephalus, congenital 152X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (the undersigned) attended the deceased from Sept. 15 , 19 60 , to Oct. 11 , 19 60 , that (I) was last saw the deceased alive on Oct. 10 , 19 60 , and that death occurred at 2A M., from the causes and on the date stated above									
22a. SIGNATURE J. H. MILLER					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-11-60		
22c. PHYSICIAN'S NAME (Type) J. H. MILLER, LT, MC, USN					22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment			23b. DATE THEREOF 10-12-60		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) Jacksonville Florida		
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co., 1400 Chapin St., N.W., WashDC					25a. REC'D BY REGISTRAR OCT 13 '60		25b. REGISTRAR'S SIGNATURE Cuthbert S. Kneass		

9VVVVVVXVV



11651

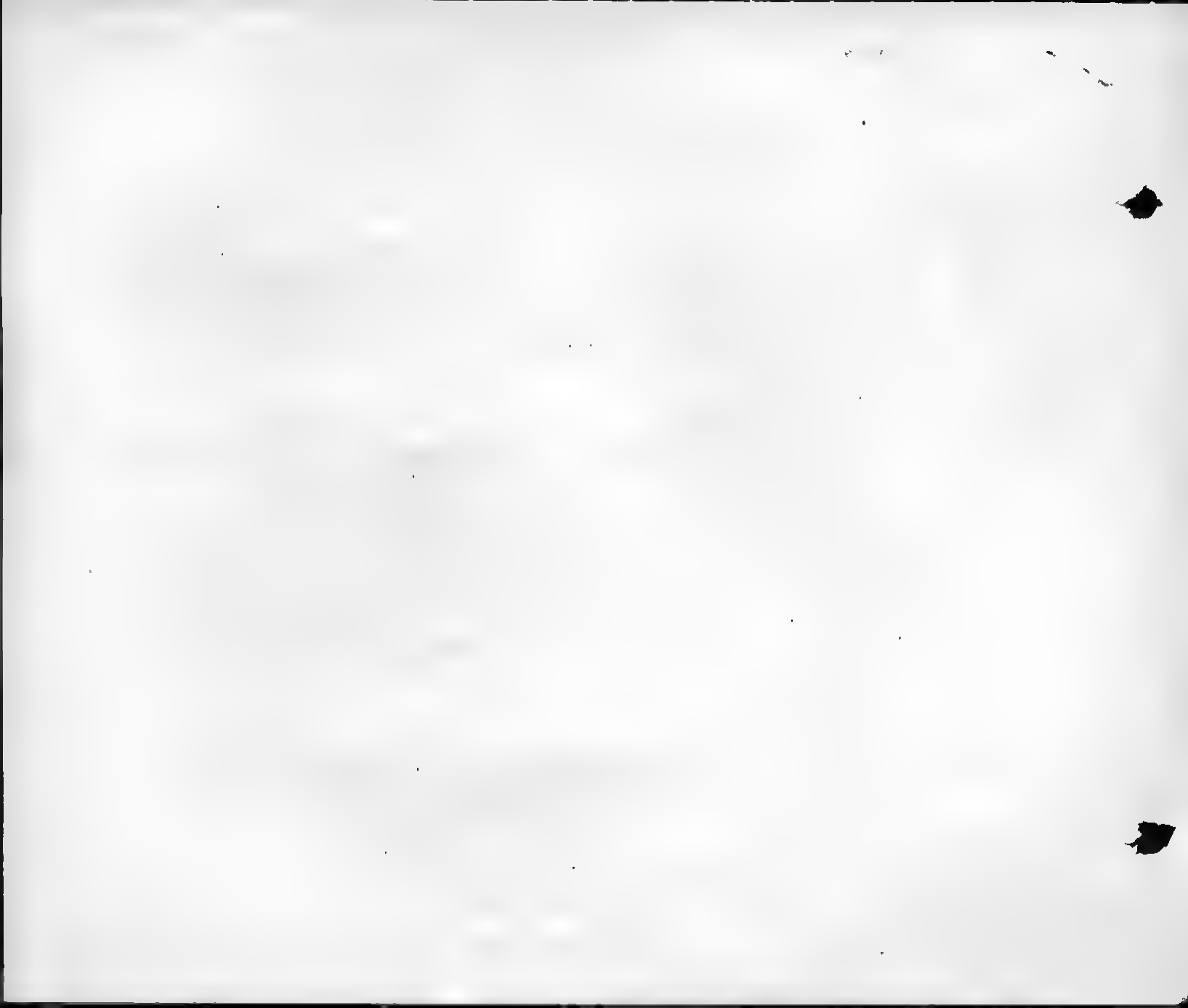
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11618

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>6 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. STREET ADDRESS <u>1670 Euclid Street, N.W.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Cora E Saunders</u>				4. DATE OF DEATH Month Day Year <u>October 19, 1960 19</u>			
5. SEX <u>f</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-27-82</u>	9. AGE (in years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Registered Nurse</u>		11. BIRTHPLACE (State or foreign country) <u>Potomac, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>NATHAN W. SAUNDERS</u>				14. MOTHER'S MAIDEN NAME <u>Adeline Clingett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>yes Unknown</u>		17. INFORMANT <u>Robert L Saunders</u> Address <u>111 Northland Bethesda, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebro-vascular Hemorrhage</u> DUE TO <u>5 Day post-OR - Valvular Cecum</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Recurrent profuse diarrhea</u> DUE TO (b) <u>4 yrs.</u> (c) <u>Senile tachycardia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>@ 6 hrs.</u> <u>@ 8 hrs.</u> <u>4 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senile tachycardia</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/13/60</u> to <u>10/19/60</u> , that (I) (we) last saw the deceased alive on <u>10/19/60</u> , and that death occurred at <u>2 PM</u> , from the causes and on the date stated above							
22a. SIGNATURE <u>Richard C. Myers MD</u>				22b. DATE SIGNED <u>10/19/60</u>		22c. PHYSICIAN'S NAME (Type) <u>ROBERT C. MYERS MD</u>	
22d. ADDRESS <u>8512 Old Georgetown Rd. Bethesda, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/21/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Potomac Ch. Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Potomac, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR <u>OCT 21 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kenna</u>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

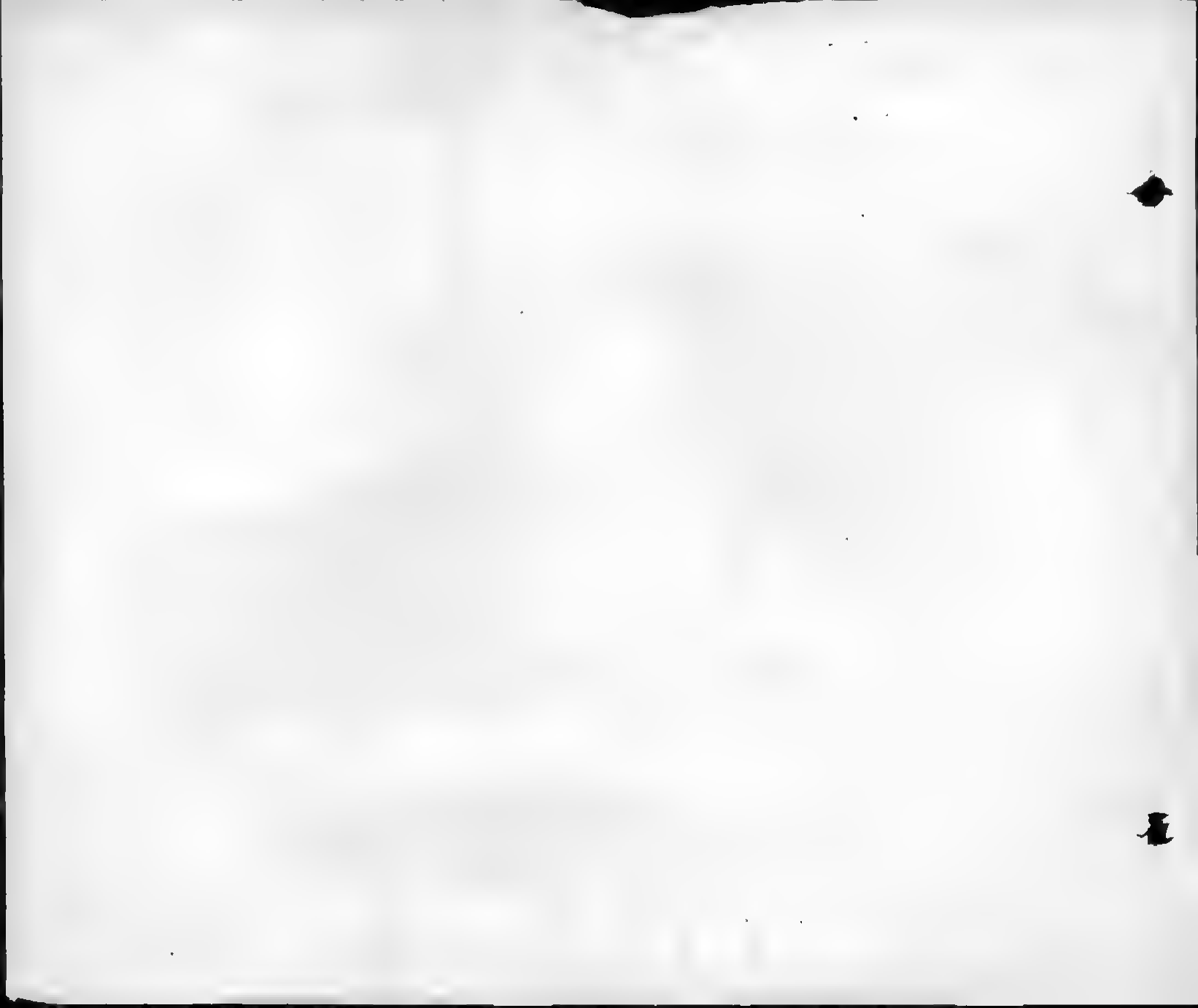
CERTIFICATE OF DEATH

11652

11619

Item 9 - Film 274 11-21-50 et

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN TB <u>9 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Savage</u> Last <u>Savage</u>		4. DATE OF DEATH Month <u>October</u> Day <u>20</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-27-86 1888</u>
9. AGE (in years lost birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager - Farm -</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>George Savage</u>		14. MOTHER'S MAIDEN NAME <u>Martha Ballenger</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>508 Longwood Dr.</u>	
17. INFORMANT <u>Son Frank Savage Jr.</u>		Address <u>Rockville, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar pneumonia</u> 490x DUE TO (b) <u>Pulmonary infarct</u> Conditions if any, which gave rise to immediate cause (c), stating the underlying cause lost. <u>?</u> DUE TO (c) <u>?</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Rozal A. Bernier</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/22/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Methodist</u>		23d. LOCATION (City, town, or county) (State) <u>Gambier Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Hilton, Baltimore Md</u>		25a. REC'D BY REGISTRAR <u>DATE OCT 25 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles S. Kline</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11653
CERTIFICATE OF DEATH

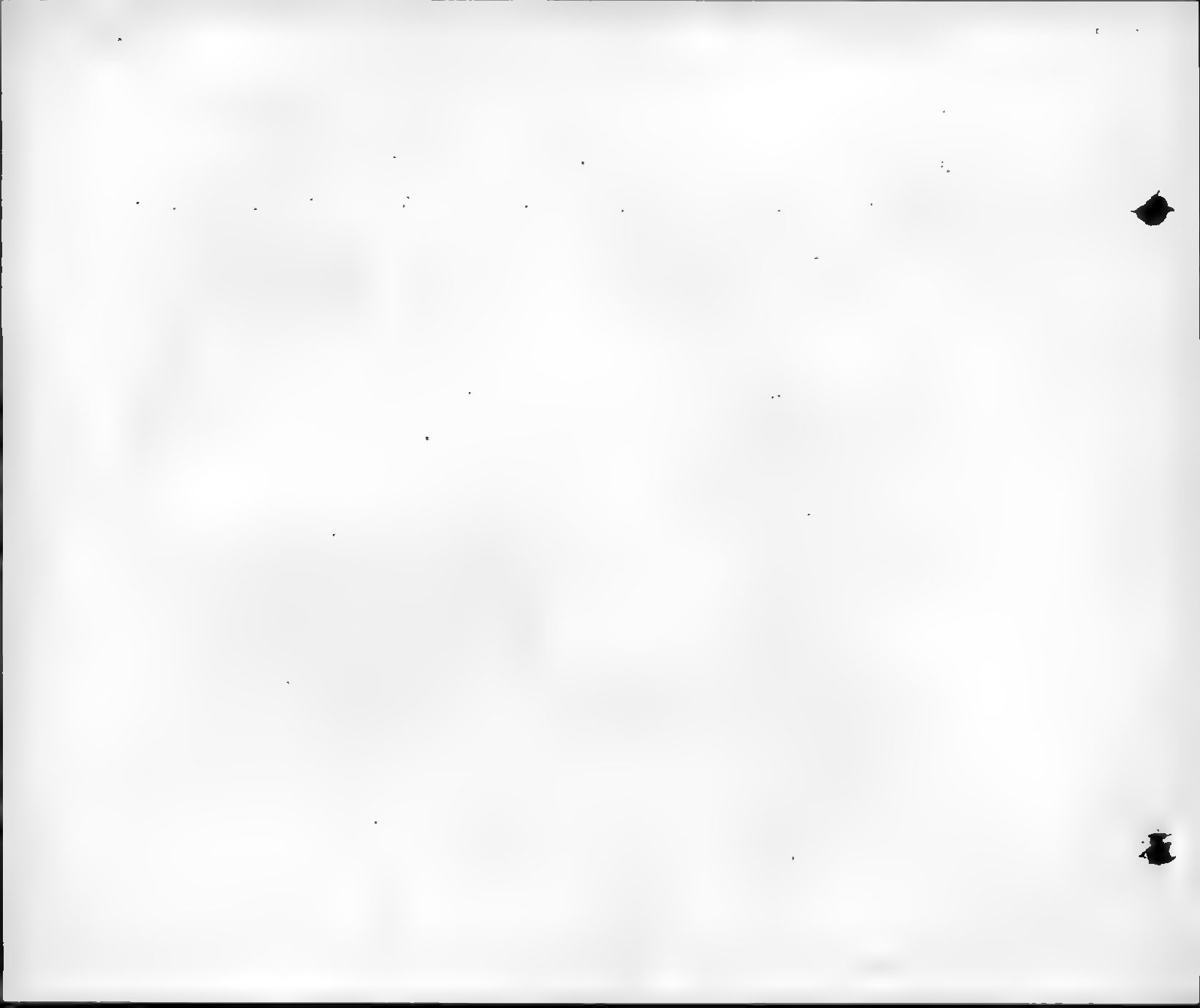
11620

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>30 hours, 6 mins.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery General Hospital</u>				d. STREET ADDRESS <u>Nichols Lane, Rockville Pike</u>			
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Michael</u> Last <u>Scalf</u>				4. DATE OF DEATH Month <u>October</u> Day <u>2</u> Year <u>19 60</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 1, 1960</u>		9. AGE (In years last birthday) <u>1</u> yrs	IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min <u>1</u>	IF UNDER 24 HRS Hours <u>1</u> Min <u>1</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>---</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Lee Carter</u>				14. MOTHER'S MAIDEN NAME <u>Betty Lou Parks</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO <u>---</u>		INFORMANT <u>Hospital Records</u>		Address <u>Olney, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>atelectasis of lungs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hemorrhage of liver</u> (c) <u>---</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>24 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>---</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>---</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 1, 1960</u> to <u>Oct. 2, 1960</u> that I last saw the deceased alive on <u>Oct. 2, 1960</u> , and that death occurred at <u>12:55 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Jack Schumacher</u>				ADDRESS (Street, city or town, state) <u>105 Rural Ave., Rockville, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Jack Schumacher M.D.</u>				DATE SIGNED <u>Oct 3, 1960</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>10/3/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		22d. LOCATION (City, town or county) (State) <u>Prince George Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler</u>				ADDRESS <u>1331 3rd Monte. Ave., Rockville, Md.</u>		24a. REC'D BY REGISTRAR <u>Oct 6 1960</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2073 214 x v 4



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
11654
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11621

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edmonston</u>	
c. LENGTH OF STAY IN 1b <u>5 days</u>		d. STREET ADDRESS <u>5104 49th Place</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jean</u> Middle <u>Margaret</u> Last <u>Schulz</u>		4. DATE OF DEATH Month <u>October</u> Day <u>16</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>19 September 1915</u>
9. AGE (In years last birthday) <u>45</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None (Housewife)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Bartel Speet</u>		14. MOTHER'S MAIDEN NAME <u>Sadie Kramer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>230-20-8674</u>	
17. INFORMANT <u>The Medical Record</u>		Address <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ovarian cystadenocarcinoma</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>October 11, 1960</u> to <u>October 16, 1960</u> , that (I) (we) last saw the deceased alive on <u>October 16, 1960</u> , and that death occurred <u>4:03 a.m.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Vincent H. Bono Jr.</u>		22b. DATE <u>10/16/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>VINCENT H. BONO, JR., M.D.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-19-60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arl. Nat'l. Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Arlington Va.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers & Co.</u>		25. REC'D BY REGISTRAR <u>Oct 19 1960</u>	
ADDRESS <u>558 Cleveland Ave. Riverdale Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	



11513

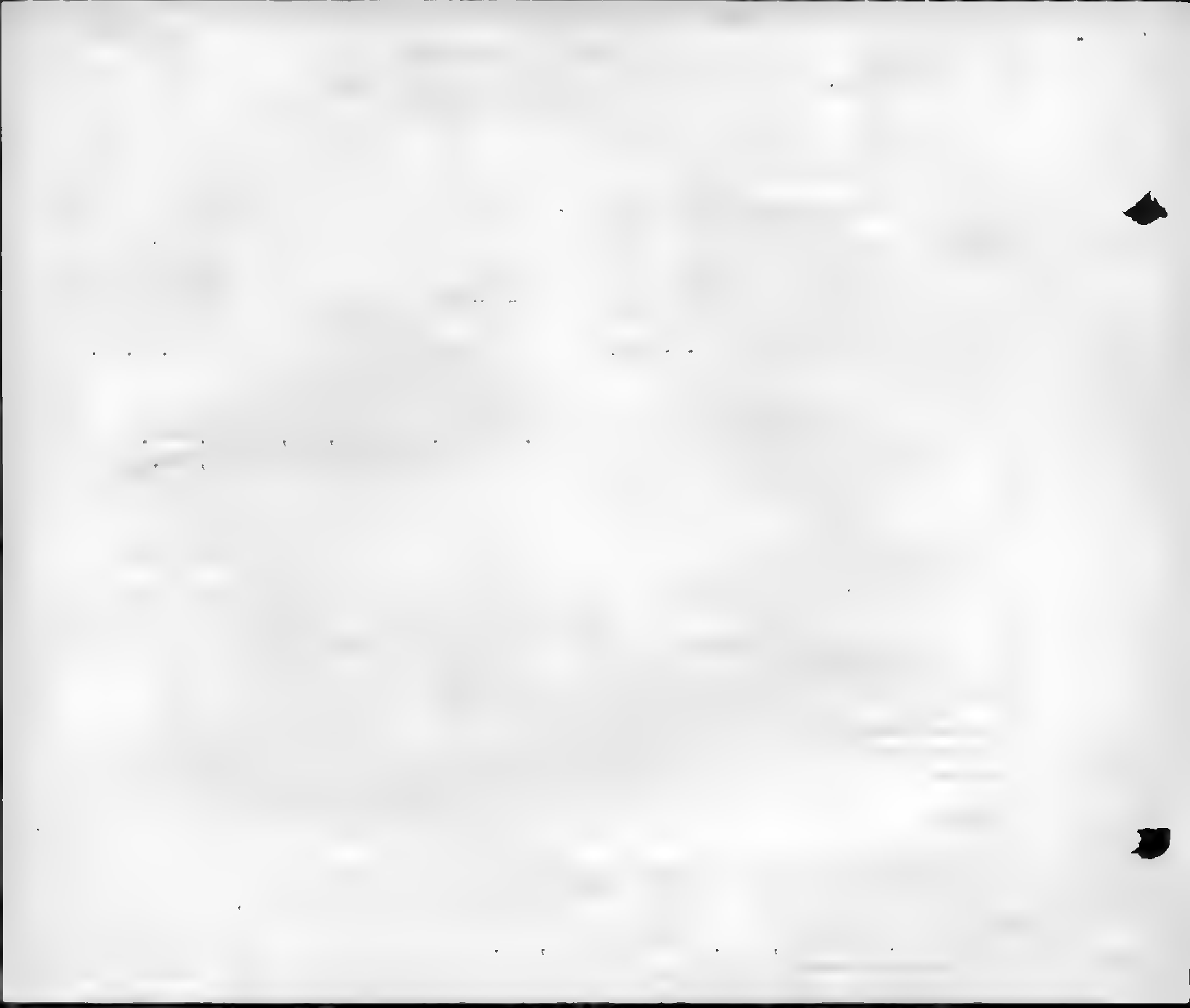
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cedarcroft Sanitarium & Hospital MONTGOMERY, MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 28 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cedarcroft Sanitarium & Hospital Inc.				d. STREET ADDRESS 12911 Georgia Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MIDDLE Last SEYFORD WILLIAM WILLIAM SEYFORD				4. DATE OF DEATH Month Day Year October 30 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/28/1876	9. AGE (In years last birthday) 84 yrs	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Navy Officer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME ALBERT SEYFORD				14. MOTHER'S MAIDEN NAME MARIE SCHILDHAUER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) WW #1 & #2		17. INFORMANT Mrs. Mary T. Seyford, 12,911 Ga. Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 45-1-0 DUE TO Congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronicized arteriosclerosis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cancer of the Colon				INTERVAL BETWEEN ONSET AND DEATH 14 hrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. p. m. 19 Month, Day, Year		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 19, 1960, to October 30, 1960, that I last saw the deceased alive on Friday, October 27, 1960, and that death occurred at 3:35 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Aldo Vacca, M.D. 12101 Columbia Pike, Silver Spring, MD 10-5-1							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/2/60		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY		22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE WERNER E. PUMPHREY, INC. Raymond A. J. J. J.				ADDRESS Silver Spring, Md.		24b. REGISTRAR'S SIGNATURE Clifford S. Thana	
24a. REC'D BY REGISTRAR DATE NOV 4 '60				24c. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11514

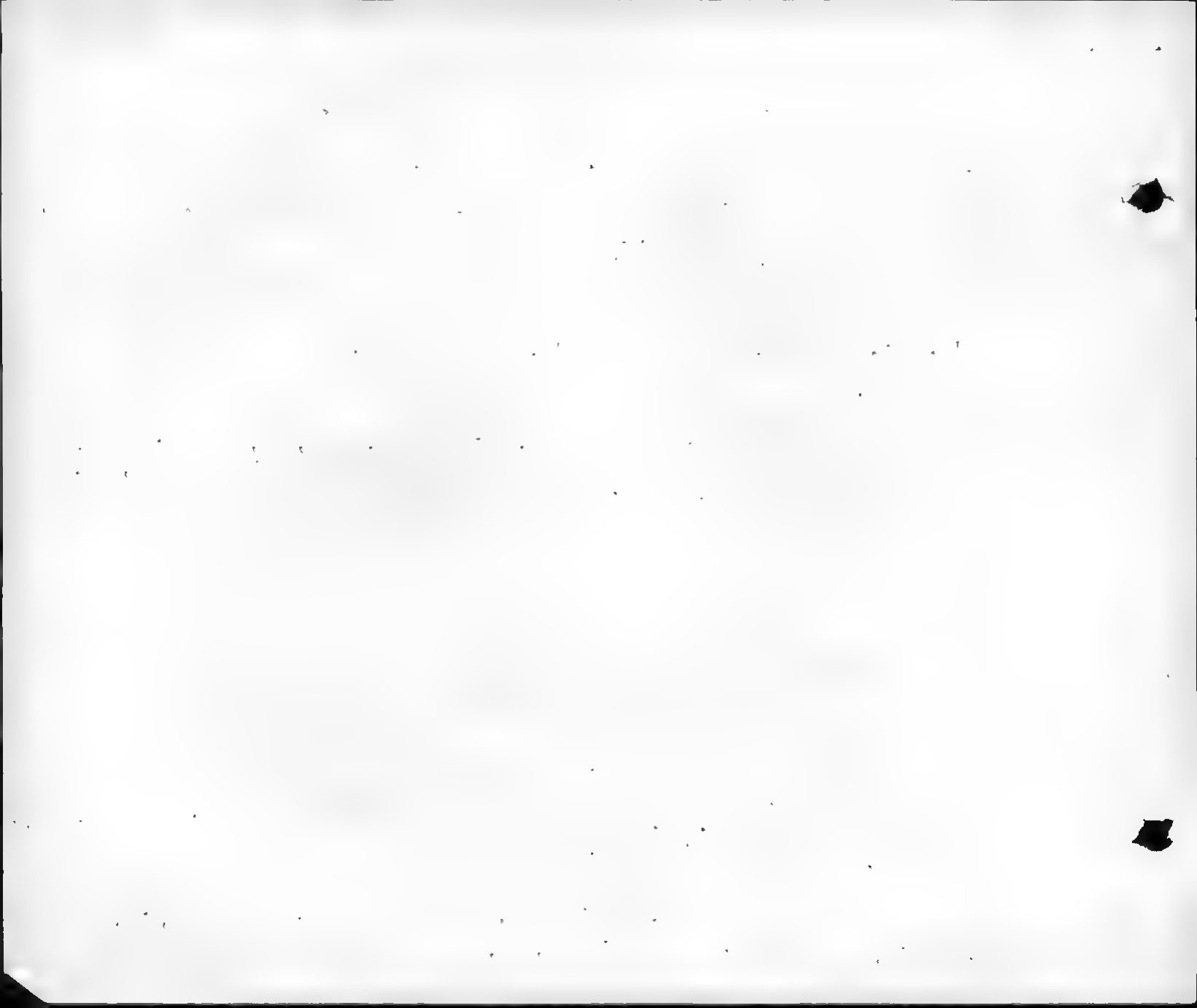
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>6 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10005 Raynor Road</u>				d. STREET ADDRESS <u>10005 Raynor Road</u>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>DOMINICK</u> Last <u>Shaw</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>7</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/21/08</u>	9. AGE (In years last birthday) <u>52</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gen'l. Mgr. Dairy Industry Supply Ass'n.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>New York</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Shaw</u>				14. MOTHER'S MAIDEN NAME <u>Ellen McNichols</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>086-07-0950</u>		INFORMANT Address <u>Mrs. Catherine M. Shaw, 10,005 Raynor Road</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>Silver Spring</u> INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> 42- DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> (County) <u> </u> (State) <u> </u>	
21. I certify that I attended the deceased from <u>Mar 24</u> , 1959, to <u>Oct 7</u> , 1960, that I last saw the deceased alive on <u>Oct 7</u> , 1960, and that death occurred at <u>8:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>345 University Blvd, West</u> DATE SIGNED <u>Oct 7, 1960</u>							
ACTUAL SIGNATURE <u>Raymond Bradshaw Jr.</u> M.D.				DATE SIGNED <u>Oct 7, 1960</u>			
PHYSICIAN'S NAME (Type) <u>Raymond Bradshaw Jr.</u>				ADDRESS <u>Silver Spring, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/10/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHN'S CATH. CEMETERY</u>		22d. LOCATION (City, town or county) (State) <u>MONTGOMERY COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR <u>Oct 11 60</u>		24b. REGISTRAR'S SIGNATURE <u>Curtis S. Thomas</u>	

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11541

11624

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN '6 <u>22 hrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>12907 Takoma Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Michael John Sheplee</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>3</u> Year <u>1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, e.g. <u>Blotter</u>)		10b. KIND OF BUSINESS OR INDUSTRY <u>Teller-Citizens Loan & Trust</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>	
13. FATHER'S NAME <u>George W. Sheplee</u>		14. MOTHER'S MAIDEN NAME <u>Sylvia Evanson</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-38-5375</u>		17. INFORMANT <u>Hosp. Record</u> Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Subdural Hemorrhage</u> DOX DUE TO (b) <u>Cerebral contusion + laceration</u> DUE TO (c) <u>fracture of skull</u>		INTERVAL BETWEEN ONSET AND DEATH <u>25 hrs.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Driver of car which left highway</u>			
20c. TIME OF INJURY Month, Day, Year <u>11:15 p.m. 10-1 1960</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>highway</u>	
20f. (City or town) <u>Silver Spring</u>		20g. County <u>Mont.</u>		20h. (State) <u>M.D.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BROSCART</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <u>10-3-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/5/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>	
22d. LOCATION (City, town, or country) <u>MONTGOMERY COUNTY, MARYLAND</u>		22e. (State) <u>M.D.</u>			
23. FUNERAL DIRECTOR <u>WALTER E. PUMPHREY, INC.</u>		ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REG/STRAR <u>OCT 6 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>					



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

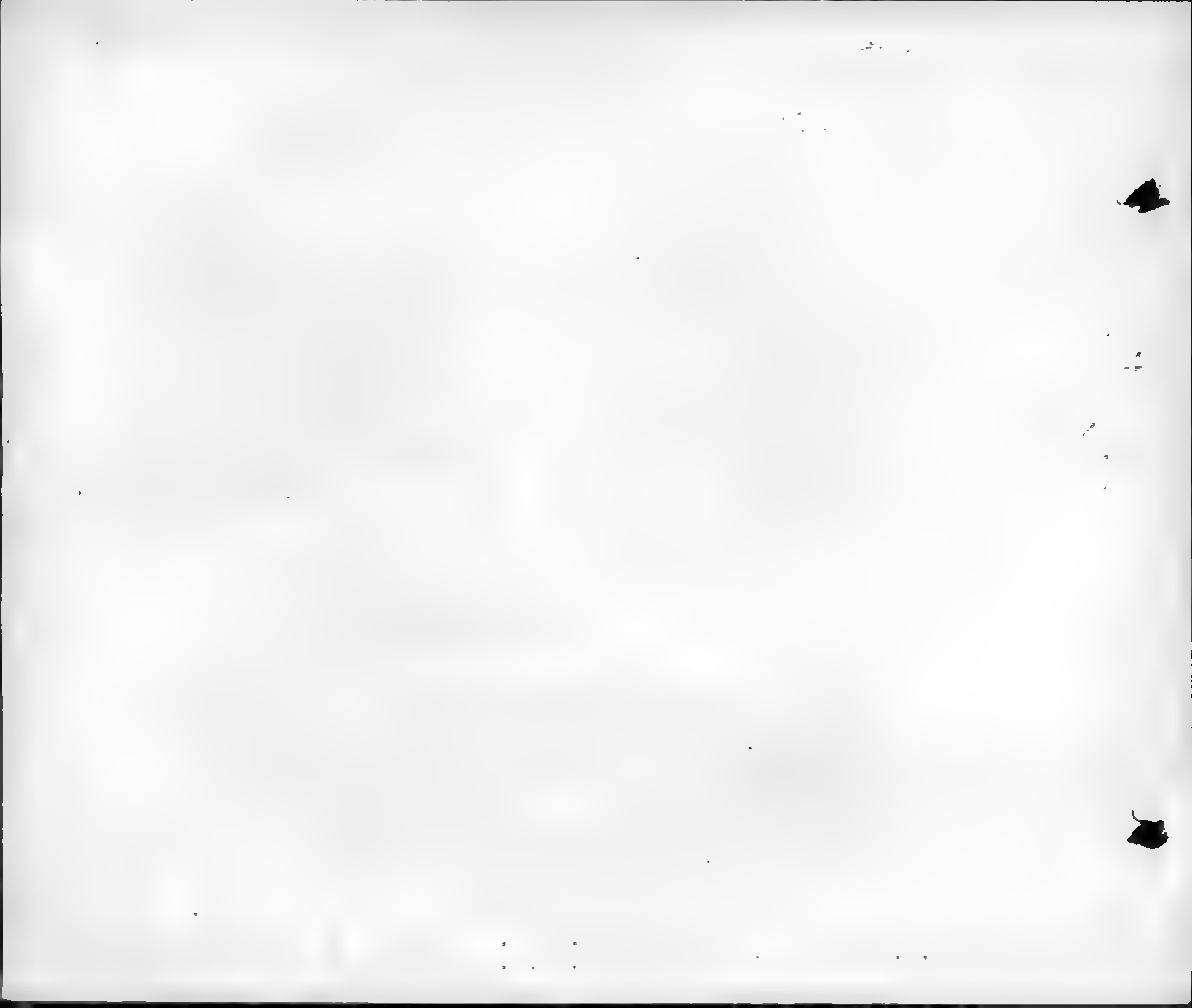
11655

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11625

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE District of Columbia b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS Conn. Ave. and E. Vermont			
3. NAME OF DECEASED (Type or print) Orville Upton Singer				4. DATE OF DEATH Oct. 1 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 1, 1892		9. AGE (In years last birthday) 68 yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) X-ray specialist		10b. KIND OF BUSINESS OR INDUSTRY Medicine		11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ? Singer				14. MOTHER'S MAIDEN NAME Nell Willie			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) No		16. SOCIAL SECURITY NO Unknown		17. INFORMANT Claire A. Singer		Address Box House, Conn. Vt. D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction DUE TO coronary atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 30 hrs							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month Day, Year Hour a. m. p. m. 9/30 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) this hospital attended the deceased from 9/30 1960 to 10/1 1960 that (II) (we) last saw the deceased alive on 10/1 1960 and that death occurred at 6 P.M. from the causes and on the date stated above.							
22a. SIGNATURE [Signature]		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/1/60			
22c. PHYSICIAN'S NAME (Type) H. F. Kreuzburg		22d. ADDRESS 7852 16th St NW Wash 12 DC					
23a. BURIAL, CREMATION, REMOVAL. (Specify) burial		23b. DATE THEREOF 10/4/60		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) (State) Suitland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.				25a. REC'D BY REGISTRAR 2901 14th St. N.W. Washington 9, D.C.		25b. REGISTRAR'S SIGNATURE Arthur L. Hines	

MEDICAL CERTIFICATION



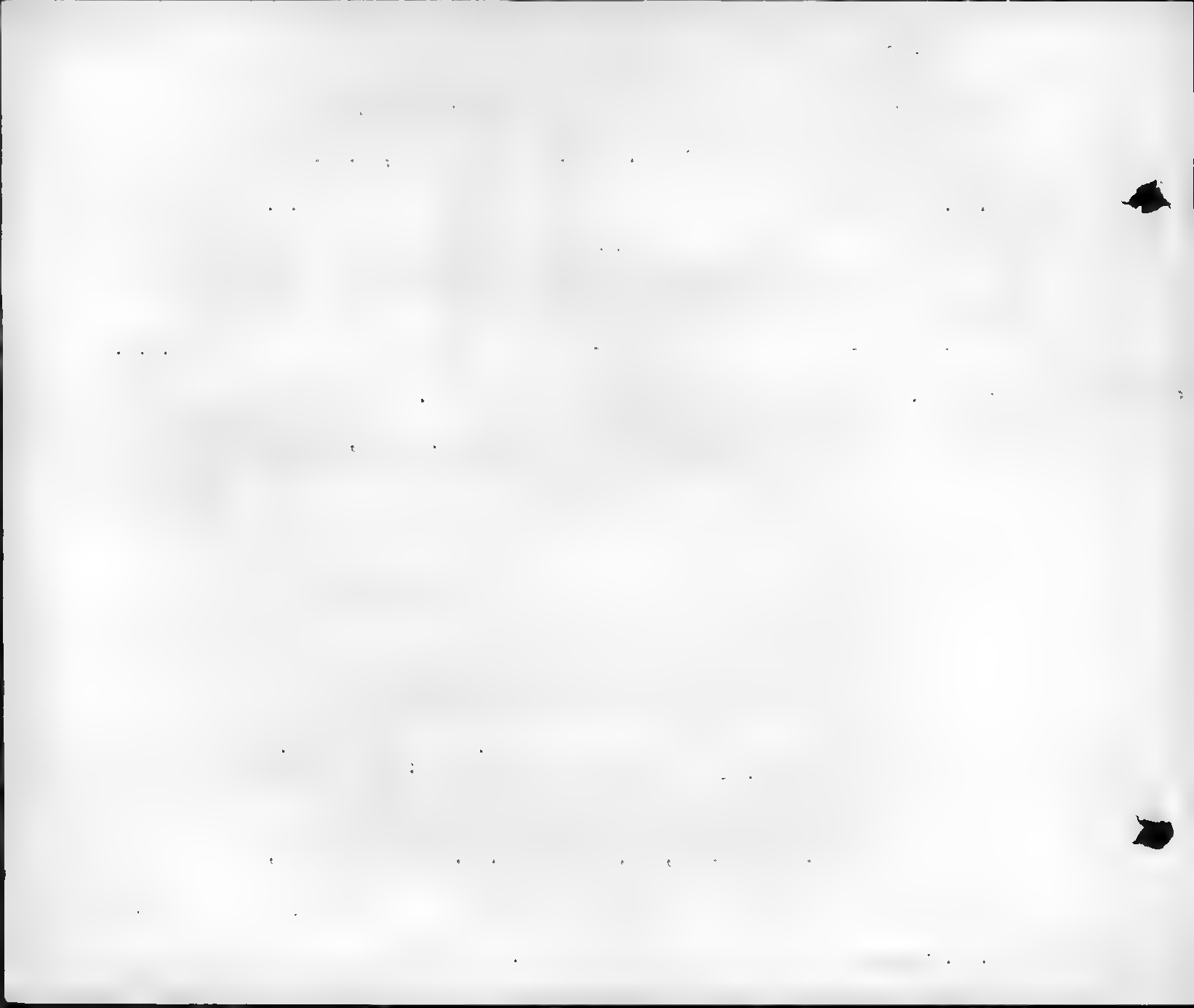
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11656

11626

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) b. STATE District of Columbia COUNTY	
b. CITY OR TOWN (If outside corporate limits, write Bethesda (Rural))		c. CITY OR TOWN (If outside corporate limits, write Washington, D. C.)	
c. LENGTH OF STAY IN 1b 2 hrs.35min.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		d. STREET ADDRESS 7 Sextant Green, S.W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First James Middle Michael Last SMITH		4. DATE OF DEATH Month October Day 1 Year 19 60	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-30-60
9. AGE (In years last birthday) yrs. 2 Months 35		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
		Maryland	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Freddy E. SMITH		14. MOTHER'S MAIDEN NAME Mabel I. JANES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT (F) Freddy E. Smith, same as #2 above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Neonatal Atelectasis 762.5 DUE TO Prematurity Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from Sept. 30 19 60 to Oct. 1 19 60 , that we last saw the deceased alive on Oct. 1 19 60 , and that death occurred at 2:10AM from the causes and on the date stated above			
22a. SIGNATURE Fred W. Grello		22b. DATE SIGNED 10-1-60	
22c. PHYSICIAN'S NAME (Type) Fred W. GRELLO, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital,	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial-Shipment 10-4-60		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Jefferson Cemetery		23d. LOCATION (City, town, or county) (State) Ottumwa Iowa	
24. FUNERAL DIRECTOR'S SIGNATURE R. R. PUMPHREY		25a. REC'D BY REGISTRAR OCT 4 '60	
ADDRESS FUNERAL HOME, Bethesda, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. K...	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



11657

CERTIFICATE OF DEATH

11627

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>North Chevy Chase</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>North Chevy Chase</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>8903 Montgomery Ave.</i>		d. STREET ADDRESS <i>8903 Montgomery Ave.</i>	
3. NAME OF DECEASED (Type or print) First <i>William</i> Middle <i>Arthur</i> Last <i>Snyder</i>		4. DATE OF DEATH Month <i>Oct.</i> Day <i>21</i> Year <i>1960</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 13, 1880</i>
9. AGE (In years last birthday) <i>79</i> yrs.		IF UNDER 1 YEAR Months <i>7</i> Days <i>19</i> Hours <i>15</i> Min <i>00</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Engineer Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>	
11. BIRTHPLACE (State or foreign country) <i>Penn.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>George W. Snyder</i>		14. MOTHER'S MAIDEN NAME <i>Mary E. Trimmer</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>577-10-4996</i>	
17. INFORMANT <i>Daughter Mary E. Jackson</i>		Address <i>8903 Montgomery Ave. Chevy Chase, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute coronary insufficiency</i> DUE TO <i>Conservative heart failure</i> DUE TO <i>Arteriosclerotic heart disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Conservative heart failure</i> (c) <i>Arteriosclerotic heart disease</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>None</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>10/21, 1960</i> , to <i>10/21, 1960</i> , that I last saw the deceased alive on <i>10/21, 1960</i> , and that death occurred at <i>11:50</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John B. Umhan</i> M.D.		ADDRESS (Street, city or town, state) <i>8805 Conn. Ave.</i>	
PHYSICIAN'S NAME (Type) <i>John Umhan</i>		DATE SIGNED <i>10/23/60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>	22b. DATE THEREOF <i>10/25/60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln Mausoleum</i>	22d. LOCATION (City, town, or county) (State) <i>Pr. Geo. Co., Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Co., 2901 14th St. N.W.</i>		24a. REC'D BY REGISTRAR DATE <i>OCT 24 '60</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11542

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11628

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If instit. on Res. before admission) a. STATE <i>Md.</i> b. COUNTY <i>D.C.</i> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington D.C. 477-2</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington San + H. Spt.</i>				d. STREET ADDRESS <i>3667 17th St.</i>			
3. NAME OF DECEASED (Type or print) First <i>C.H.</i> Middle <i>NAIN</i> Last <i>Solomon</i>				4. DATE OF DEATH Month <i>10</i> Day <i>3</i> Year <i>1960</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-19-83</i>	9. AGE (In years lost birthday) <i>77</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Telephone Co.</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>Am. C.</i>	
13. FATHER'S NAME <i>Samuel Solomon</i>				14. MOTHER'S MAIDEN NAME <i>Sigga Anna Jenkins</i> <i>Ph's Hspt. record Washington San + Hspt.</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>↓</i>		Address <i>↓</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Broncho pneumonia</i> <i>6107</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Acute Cystitis</i> DUE TO (c) <i>Prostatic hypertrophy</i>						INTERVAL BETWEEN ONSET AND DEATH <i>4 da</i> <i>7 da</i> <i>many years</i>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>① Parkinson's Disease</i> (b) <i>Carcinoma of Stomach</i> <i>Lesser curvature</i>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <i>9-22-1960</i> to <i>10-3-1960</i> that (I) (we) last saw the deceased alive on <i>10-3-1960</i> , and that death occurred at <i>10:30 AM</i> from the causes and on the date stated above							
22a. SIGNATURE <i>James W. [Signature]</i> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>10-3-60</i>	
22c. PHYSICIAN'S NAME (Type) <i>James W. [Signature]</i>				22d. ADDRESS <i>4712 Canaan Ave Takoma Park Md</i>			
23a. BURIAL, CREMATATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>10-6-60</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Louisa Park</i>		23d. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Real Funeral Home</i>				ADDRESS <i>4812 9th Ave N.W. Wash. D.C.</i>		25a. REC'D BY REG. STRAR DATE <i>OCT 6 '60</i>	
				25b. REGISTRAR'S SIGNATURE <i>Charles S. Kraus</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be rechecked by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



I)

11629

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakoma Park</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. San & Hosp</u>		e. STREET ADDRESS <u>7114 Woodland Ave. 1</u>	
3. NAME OF DECEASED (Type or print) <u>Harvey Albert Stacy</u>		4. DATE OF DEATH Month <u>8</u> Day <u>14</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/14/1881</u>
9. AGE (in years lost birthday) yrs <u>79</u>		10. UNDER 1 YEAR IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired <u>Retired Book</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MASS.</u>	
11. BIRTHPLACE (State or foreign country) <u>MASS.</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMERICA</u>	
13. FATHER'S NAME <u>Albert Stacy</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Crockett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Wash. San & Hosp record.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary occlusion</u> DUE TO (c) <u>Ch. Reg. myocarditis occ. Decomp.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u> <u>4 yrs.</u> <u>13 yrs.</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3/9/1949</u> to <u>10/28/1960</u> that (I) (we) last saw the deceased alive on <u>10/28/1960</u> and that death occurred at <u>9:30</u> M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Howard T. Morse</u>		22b. DATE <u>10/28/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Howard T. Morse</u>		22d. ADDRESS <u>7030 Carroll Ave. Takoma Park Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/31/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Adelphi Prince Georges Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u>		25a. REC'D BY REGISTRAR <u>Arthur Walters</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur Walters</u>		25c. DATE <u>NOV 1 '60</u>	

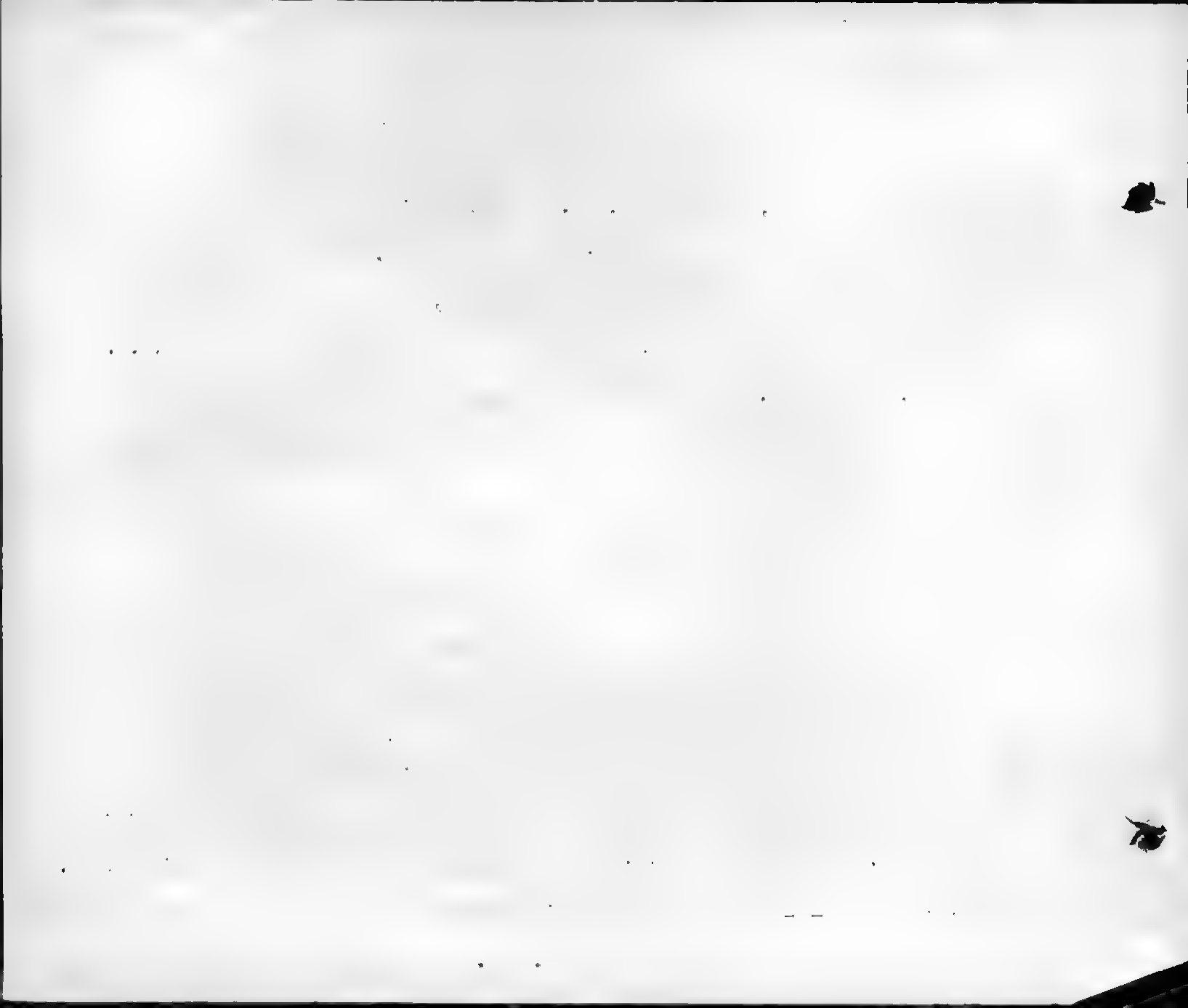


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11630

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE West Virginia b. COUNTY <input checked="" type="checkbox"/>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 66 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Martinsburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS Route # 3			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Roland Middle Seibert Last Tabler, Jr.				4. DATE OF DEATH Month October Day 31 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 20, 1948		9. AGE (In years last birthday) 12 yrs.	10. UNDER 1 YEAR Months 12 Days 12 Hours 12 Min.	11. UNDER 24 HRS Months 12 Days 12 Hours 12 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Roland S. Tabler, Sr.				14. MOTHER'S MAIDEN NAME Anna Swartz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Septicemia DUE TO (b) Acute Lymphatic Leukemia DUE TO (c) Acute Lymphatic Leukemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 2 Weeks 2 1/2 Years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from August 26, 1960 to October 31, 1960 , that (I) (we) last saw the deceased alive on October 31, 1960 , and that death occurred at 6:05 PM on the causes and on the date stated above.							
22a. SIGNATURE <i>W. Walter Oppelt</i>				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 11-1-60	
22c. PHYSICIAN'S NAME (Type) W. WALTER OPPELT, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
23a. RITUAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-3-1960		23c. NAME OF CEMETERY OR CREMATORY Pleasant View Memory Gardens		23d. LOCATION (City, town, or county) (State) Martinsburg, West Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Howard L. Brown</i>				ADDRESS Martinsburg, W. Va.		25a. REC'D BY REGISTRAR DATE NOV 3 '60	
				25b. REGISTRAR'S SIGNATURE <i>Charles E. Thomas</i>			

(10) HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

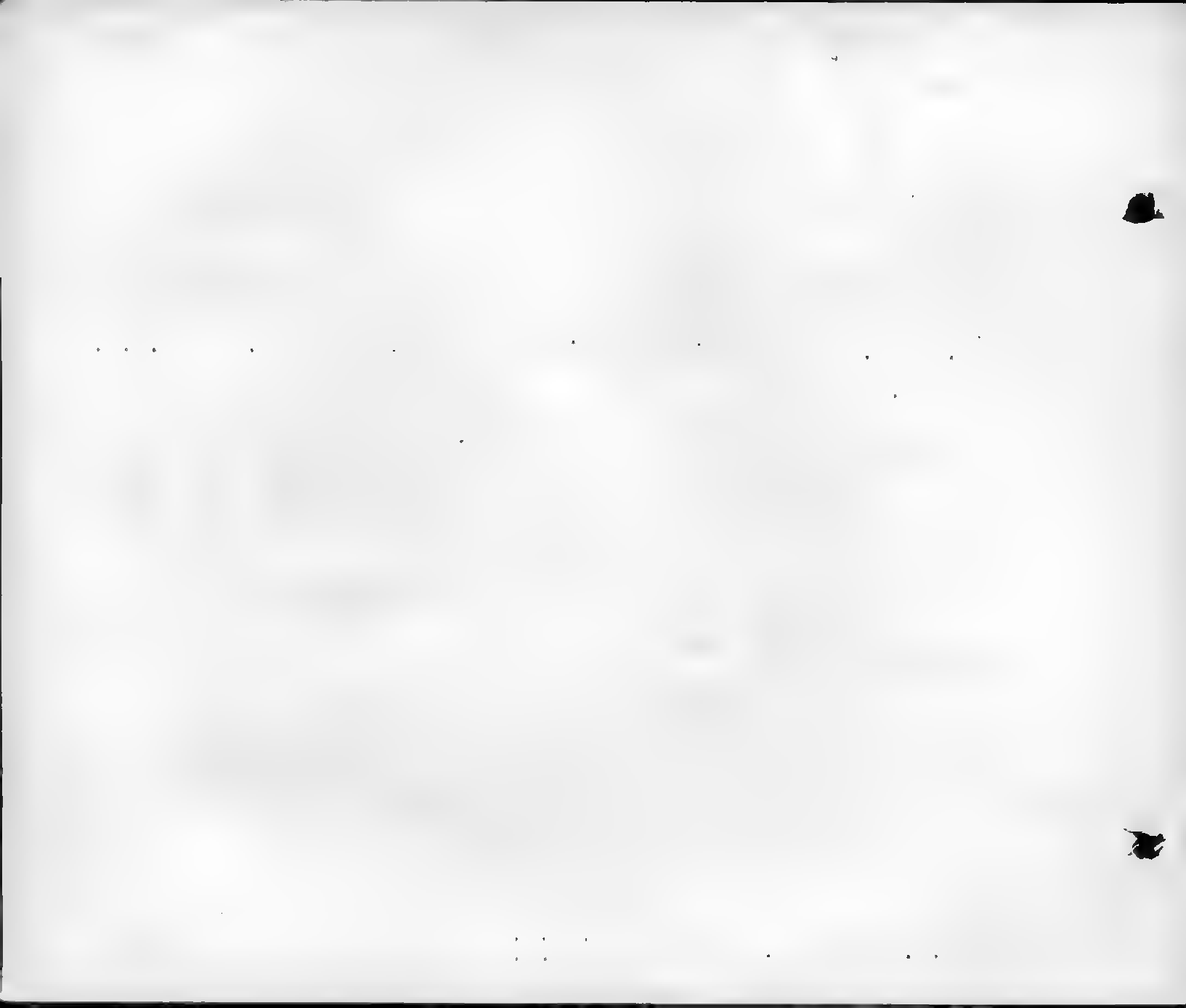
VR A15 (4)
15M 9/59

11659

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11631

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>D.C.</i> b. COUNTY <i>✓</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wheaton Md.</i>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Wheaton Nursing Home</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>H.</i> Middle <i>Theodore</i> Last <i>Tate</i>				4. DATE OF DEATH Month <i>Oct</i> Day <i>23</i> Year <i>1960</i>			
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>12/28/75</i>	
9. AGE (In years last birthday) <i>84 yrs</i>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Adm. Asst. to chief disbursing officer</i>				11. BIRTHPLACE (State or foreign country) <i>Tenn.</i>			
13. FATHER'S NAME <i>Allen S. Tate</i>				14. MOTHER'S MAIDEN NAME <i>Arianna Peck</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Mary A. Tate</i>		Address <i>same as #2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral accident (Thrombosis)</i> 4200 DUE TO <i>Advanced generalized arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>arteriosclerotic H.D.</i> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>many years.</i>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Fall & contused sprain R hip (no fracture)</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury on Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <i>1956</i> to <i>10/23</i> 19 <i>60</i> , that (I) (we) last saw the deceased alive on <i>10/22</i> 19 <i>60</i> , and that death occurred at <i>6:15</i> PM, from the causes and on the date stated above.			
22a. SIGNATURE <i>Richard T Sullivan M.D.</i>		22b. DATE SIGNED <i>10/23/60</i>		22c. PHYSICIAN'S NAME (Type) <i>Richard T Sullivan M.D.</i>		22d. ADDRESS <i>1800 Eye St NW Wash D.C.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>removal</i>		23b. DATE THEREOF <i>10/25/60</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Emma Jarnigan Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Morristown, Tenn.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Co.</i>				25a. REC'D BY REGISTRAR <i>2901 14th St. N.W. Washington 9, D.C.</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11515

CERTIFICATE OF DEATH

11632

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institut an: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MARILEA NURSING HOME		e. STREET ADDRESS 10,002 ROGART ROAD	
3. NAME OF DECEASED (Type or print) First CATHERINE Middle M N Last TEEHAN		4. DATE OF DEATH Month Oct. Day 11 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/4/63
9. AGE (In years last birthday) 97 yrs.		10. IF UNDER 1 YEAR Months 6 Days 15 Hours 15 Min.	11. IF UNDER 24 HRS Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) ST. LOUIS, MISSOURI
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME WILLIAM J. BARRY	
14. MOTHER'S MAIDEN NAME HONORA (UNKNOWN)		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO NONE		17. INFORMANT Mrs. Esther Specht, 10,002 Rogart Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Congestive Heart Failure 45c. 10 DUE TO (b) Senile Arteriosclerosis, Generalized DUE TO (c) 15 yrs. INTERVAL BETWEEN ONSET AND DEATH 15 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1946 , 19 11 Oct , 19 60 , that I last saw the deceased alive on 8 Oct. , 19 60 , and that death occurred at 9 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7112 Willow Ave DATE SIGNED 11 Oct 1960 ACTUAL SIGNATURE H. B. Queen M D TAKOMA PARK, MD PHYSICIAN'S NAME (Type) H. B. QUEEN			
22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 10/15/60	22c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY	22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC., SILVER SPRING, MD. Raymond A. Zelen		24a. REC'D BY REGISTRAR DATE OCT 19 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kneel

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

Acute lymphatic leukemia
100 100 100 100 100 100 100 100 100 100

100 100 100 100 100 100 100 100 100 100
100 100 100 100 100 100 100 100 100 100
100 100 100 100 100 100 100 100 100 100
100 100 100 100 100 100 100 100 100 100

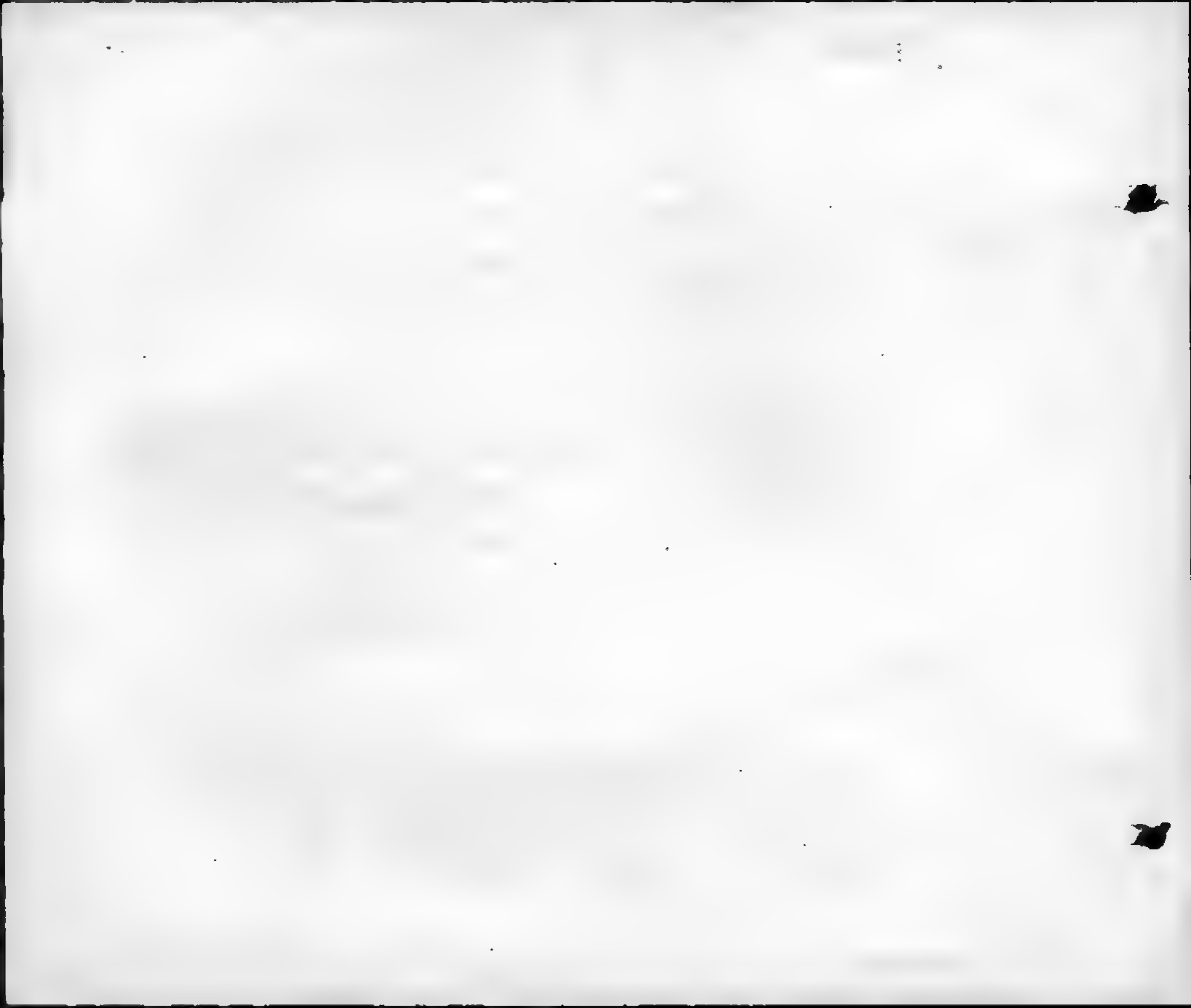
may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11660

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11633

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>23 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Selman</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>Box 34</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Joseph M. Thompson</u>				4. DATE OF DEATH Month Day Year <u>October 16 1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 21, 1893</u>		9. AGE (In years lost birthday) <u>67</u> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		
13. FATHER'S NAME <u>George W. Thompson</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Bourne</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-24-7634</u>		17. INFORMANT <u>Emma J. Thompson (Wife)</u>		Address <u>As above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral vascular Thrombosis</u> (b) <u>arteriosclerotic cardiovascular disease</u> (c) <u>lying cause last.</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs</u> <u>10 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9/23 1960</u> to <u>10/16 1960</u> , that (I) (we) last saw the deceased alive on <u>10/16 1960</u> , and that death occurred at <u>10/17 1960</u> AM, from the causes and on the date stated above							
22a. SIGNATURE <u>Frederick Y. Donn</u>				22b. DATE SIGNED <u>10/17/60</u>		22c. PHYSICIAN'S NAME (Type) <u>Frederick Y. Donn</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>10/19/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rocklawn</u>	
23d. LOCATION (City, town, or county) <u>Bethesda</u>				23e. (State) <u>MD</u>		23f. (Country) <u>USA</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Esther C. Hilton</u>				ADDRESS <u>Baltimore, Md.</u>		25a. REC'D BY REGISTRAR <u>OCT 20 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>				25c. (City, town, or county) <u>Baltimore</u>			



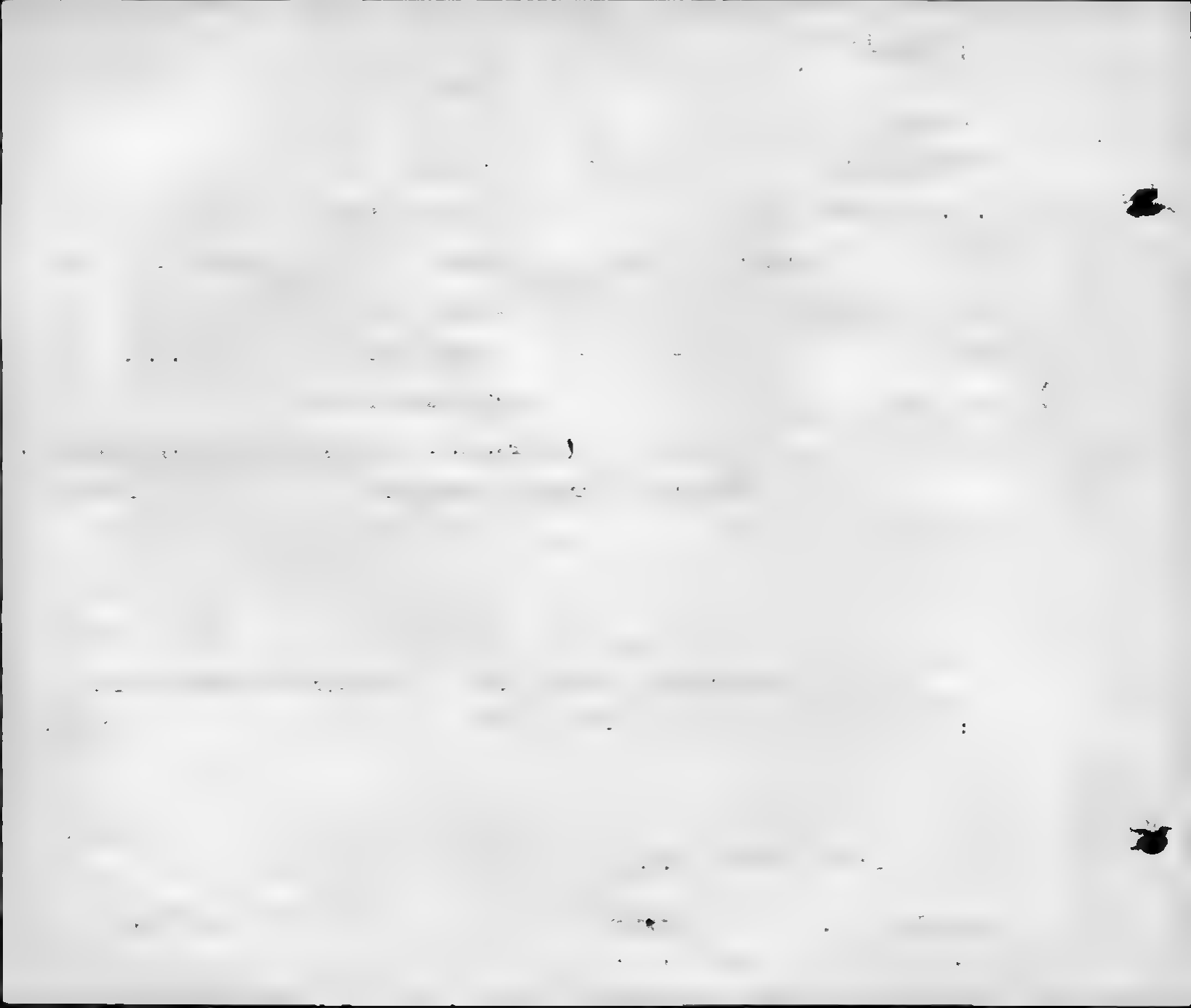
1
FOR STATE
HEALTH DEPT.

TO FUTURE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the information is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

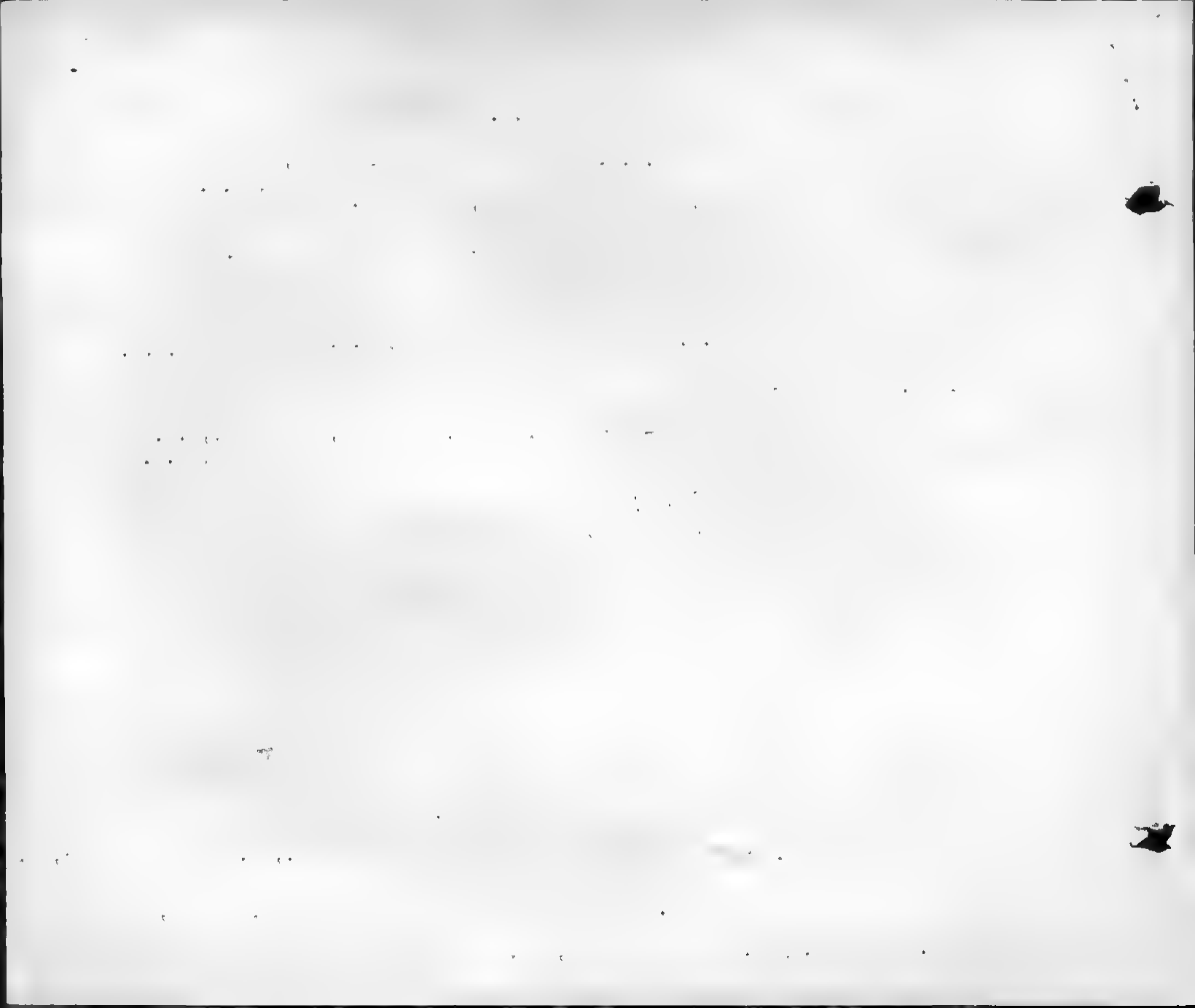
MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH																																							
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																																							
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																																							
11661																																							
11634																																							
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN TB 10 hours d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Virginia b. COUNTY Triangle c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Triangle d. STREET ADDRESS 148 Wain Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																		
3. NAME OF DECEASED (Type or print) Arthur Earl TOWNE					4. DATE OF DEATH Month October Day 1 Year 1960																																		
5. SEX Male					6. COLOR OR RACE Caucasian																																		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>					8. DATE OF BIRTH 4-14-42																																		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student					10b. KIND OF BUSINESS OR INDUSTRY Massachusetts																																		
11. BIRTHPLACE (State or foreign country) U.S.A.					12. CITIZEN OF WHAT COUNTRY? U.S.A.																																		
13. FATHER'S NAME George TOWNE					14. MOTHER'S MAIDEN NAME Marie Elsie SYLVESTER																																		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No					16. SOCIAL SECURITY NO. (M) Mrs. R.W. Pethick, 148 Wain Dr., Triangle, Va.																																		
17. INFORMANT (M) Mrs. R.W. Pethick, 148 Wain Dr., Triangle, Va.					Address																																		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage & laceration DUE TO (b) 2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) 12 hours INTERVAL BETWEEN ONSET AND DEATH 12 hours																																							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18) Was driver of car that left road and struck telephone pole. 20c. TIME OF INJURY Month Day Year 11:58 9-30 1960 20d. INJURY OCCURRED: While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Marine Base 20f. (City or town) (County) (State) Quantico Virginia																																							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Frank Broschart, M.D. 10-1-60																																							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal										22b. DATE THEREOF Oct. 4 1960										22c. NAME OF CEMETERY OR CREMATORY Nickerson Funeral Home										22d. LOCATION (City, town, or county) (State) Manassas, Va.									
23. FUNERAL DIRECTOR J. Dennis Baker										24a. REC'D BY REGISTRAR Oct 5 '60										24b. REGISTRAR'S SIGNATURE Charles L. Hines																			



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> 11544 CERTIFICATE OF DEATH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND 11635 </div>									
1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK			c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON, D.C.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SAN. & HOSPITAL					d. STREET ADDRESS 615 A Street, N.E. 12,302 MIDDLE ROAD				
3. NAME OF DECEASED (Type or print) FRANK HARRY TOWNE					4. DATE OF DEATH Month OCT. Day 9 Year 1960				
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/17/79		9. AGE (In years lost birthday) 80 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) Washington, D.C.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME FRANK H. TOWNE, SR.					14. MOTHER'S MAIDEN NAME LAURA PUMPHREY				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO 578-18-4396		17. INFORMANT Address Mrs. Ann G. Martinez, 615 A St., N.E. Washington, D.C.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis (b) DUE TO Chronic Crohn's (c) DUE TO Chronic Crohn's INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a m p m 19			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 10/5 to 10/9, 1960 that (I) (we) lost the deceased alive on 10/8, 1960 and that death occurred at 10 AM, from the causes and on the date stated above.									
22a. SIGNATURE Bennett A. Robin					22b. DATE 10/11/60				
22c. PHYSICIAN'S NAME (Type) BENNETT A. ROBIN					22d. ADDRESS 317 University Blvd., E., Silver Spring, Md.				
23a. BURIAL, CREMATION, REMOVA- (Specify) BURIAL		23b. DATE THEREOF 10/12/60		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY			23d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MARYLAND		
24. FUNERAL DIRECTOR'S SIGNATURE WALTER E. PUMPHREY, INC.					25a. REC'D BY REGISTRAR 10/14/60		25b. REGISTRAR'S SIGNATURE Arthur L. Harris		



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

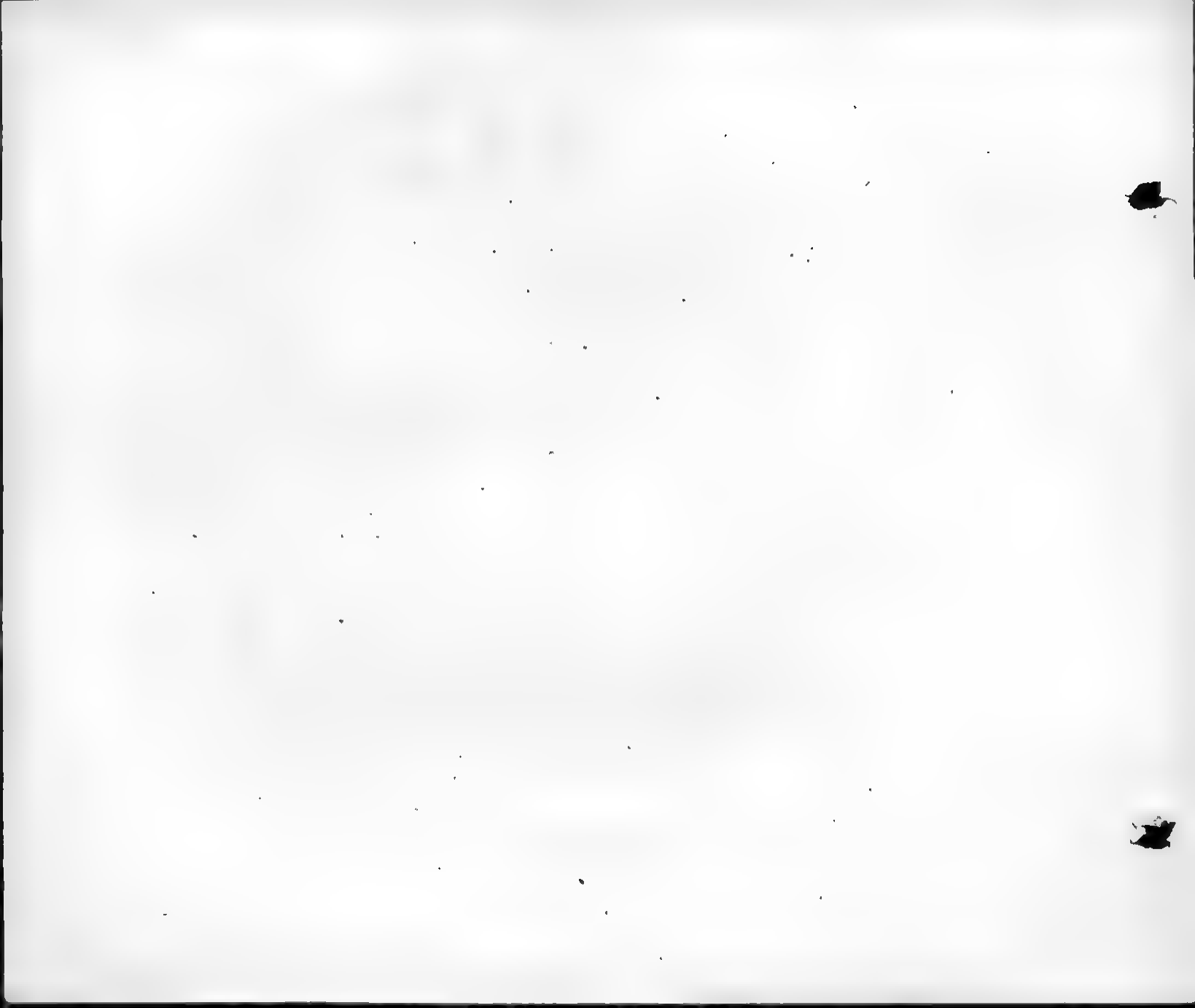
Reg. Dist. No.

11636

11516

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>			
c. LENGTH OF STAY IN 1b <u>12 YEARS</u>				d. STREET ADDRESS <u>19411 WIRE AVE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9411 WIRE AVE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MICHAEL ANTONIO TOZZOLO</u>				4. DATE OF DEATH Month Day Year <u>10 11 1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB 8, 1904</u>	
9. AGE (In years last birthday) <u>56</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRUCK DRIVER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>SOUTHERN DAIRY</u>			
11. BIRTHPLACE (State or foreign country) <u>ITALY</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>VINCENT TOZZOLO</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>UNK</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>577-07-4500</u>			
INFORMANT <u>MICHAEL TOZZOLO</u> Address <u>2102 Cascade Rd. S.S. MD.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>421.1</u> <u>respiratory failure</u> DUE TO <u>long standing cardiac decompensation</u> (b) <u>arterio-sclerosis</u> (c) <u>hypertension</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>hypertension</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Sept 2, 1958</u> , to <u>present</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>10-8</u> , 19 <u>60</u> , and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard P. Delaney</u> M.D. <u>4323</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>10/11/60</u>			
PHYSICIAN'S NAME (Type) <u>RICHARD P. DELANEY, MD. Silver Spring, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 14, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>mt. Olivet</u>		22d. LOCATION (City, town, or county) (State) <u>WASH. D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Taltavull</u> ADDRESS <u>3603 14th St. NW Wash. D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 13 '60</u>			
24b. REGISTRAR'S SIGNATURE <u>Charles E. Kume</u>							

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/59

1
 11545

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11637

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <u>5718 Ager Rd.</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>75 Wash San Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Francis Tucker</u>				DATE OF DEATH Month <u>10</u> Day <u>8</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-7-09</u>	
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk State Dept.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Samuel Tucker</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Kirby</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>not known</u>		17. INFORMANT Address <u>Chart (Hospital)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>intermittent Colitis Fulminans</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>approx 20 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 17, 1940</u> to <u>Aug 7, 1960</u> , that (I) (we) last saw the deceased alive on <u>10/7</u> 19 <u>60</u> , and that death occurred at <u>1:35 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Wayne Olickfield</u> M.D.				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>WAYNE OLICKFIELD M.D.</u>				22d. ADDRESS <u>6826 Riggs Rd. Hyatts. Md.</u>			
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
<u>Burial</u>		<u>10-12-60</u>		<u>St. Olivet</u>		<u>Wash. D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>H. G. H. H. H.</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 11 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

11662

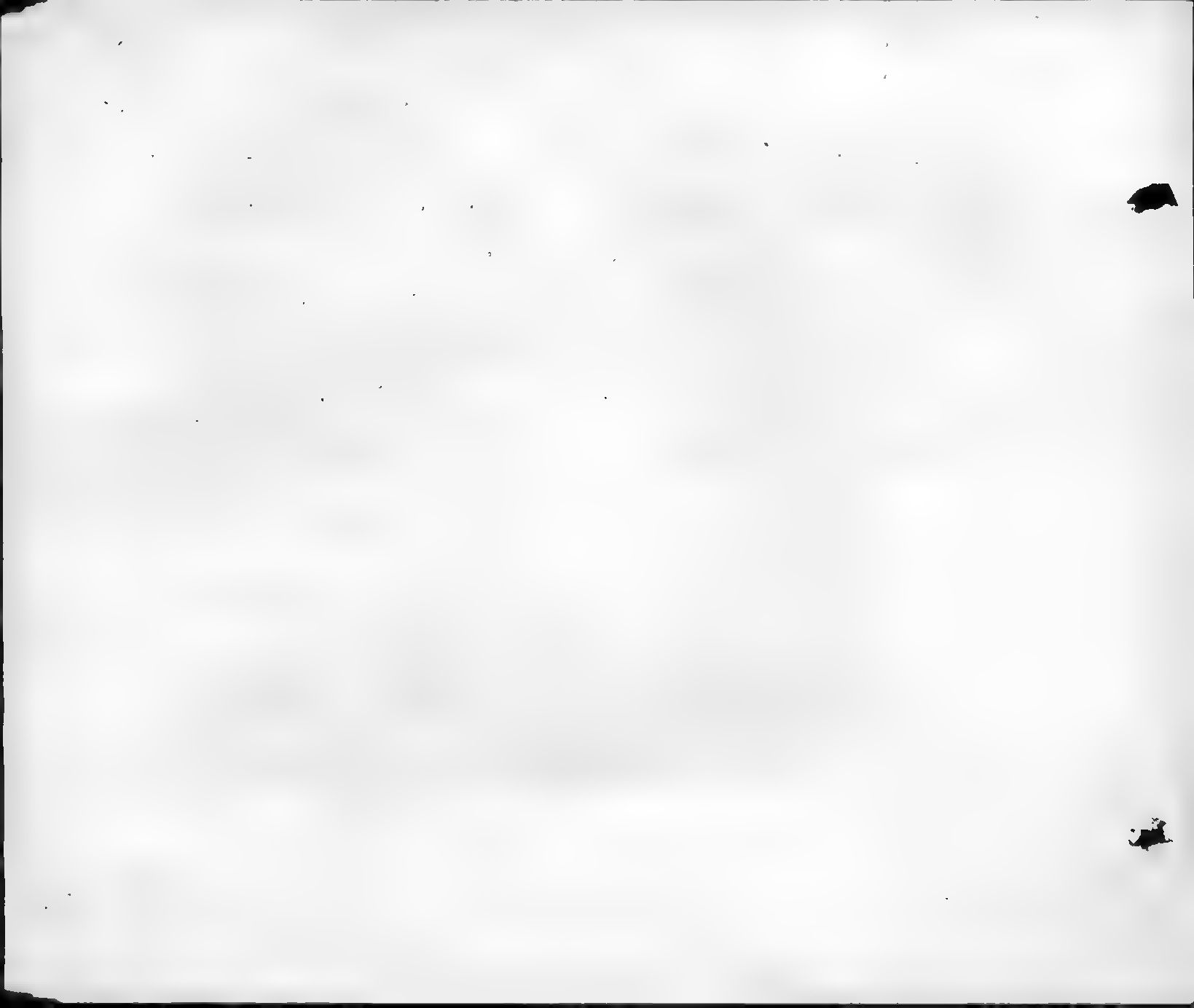
1

11662

CERTIFICATE OF DEATH

11668

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING (Rural)				c. LENGTH OF STAY IN 1b 10 Yrs. +			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 12801 LAYHILL ROAD				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EVA Middle J. Last TURNER				4. DATE OF DEATH Month Oct - Day 31 - Year 1960			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAR. 15, 1874	
9. AGE (In years last birthday) 86 yrs		IF UNDER 1 YEAR Months 7 Days 15		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) REALTOR		10b. KIND OF BUSINESS OR INDUSTRY REAL ESTATE		11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES HENRY PARKER				14. MOTHER'S MAIDEN NAME MARAB SMEDLEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MR. ALBERT PARKER		Address MONTGOMERY CO. R.F.D.	
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Advanced generalized arteriosclerosis DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 3 days 10 yrs	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1953 to Oct 1960 , that (I) (we) last saw the deceased alive on Oct 30 1960 , and that death occurred at 2:20 PM , from the causes and on the date stated above.							
22a. SIGNATURE A. D. Bonifant				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) A. D. BONIFANT				22d. ADDRESS Sandy Spring, Md.			
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-3-60		23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEM.		23d. LOCATION (City, town, or county) (State) PRINCE GEO. CO., MD.	
24. FUNERAL DIRECTOR'S SIGNATURE Martin W. Hyson Co.				ADDRESS 1300 N ST. N.W. WASH. D.C.		25a. REC'D BY REG. STRAR NOV 2 '60 DATE	
				25b. REGISTRAR'S SIGNATURE Arthur L. Kneel			



CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institut. a Residence before admission) b. STATE Virginia		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 59 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norfolk		822	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS 1213 Holladay Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print)		First Alma		Middle Jean		Last TUTHILL	
5 SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF DEATH Month October	
				B. DATE OF BIRTH 5-25-30		9. AGE (in years last birthday) 30 yrs	
						IF UNDER 1 YEAR Months 3	
						Day 19	
						Year 60	
10a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ira MIDGETT				14. MOTHER'S MAIDEN NAME Rena TILLET			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (H) Mr. J.R.Tuthill, 12707 Barbara Rd., SS, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 153.8 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Metastatic Carcinoma to Liver & Lung Primary Carcinoma of Colon DUE TO 5 months						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (husband) attended the deceased from August 5, 1960 to October 3, 1960 that (I) (see) last saw the deceased alive on October 3, 1960 and that death occurred at 9P M, from the causes and on the date stated above.							
22a. SIGNATURE L. G. Muth		M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 10-3-60	
22c. PHYSICIAN'S NAME (Type) R. G. MUTH, LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-5-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler		ADDRESS Funeral Home, Rockville, Md.		25a. REC'D BY REGISTRAR DATE OCT 5 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 42 hours after death.

11664

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11640

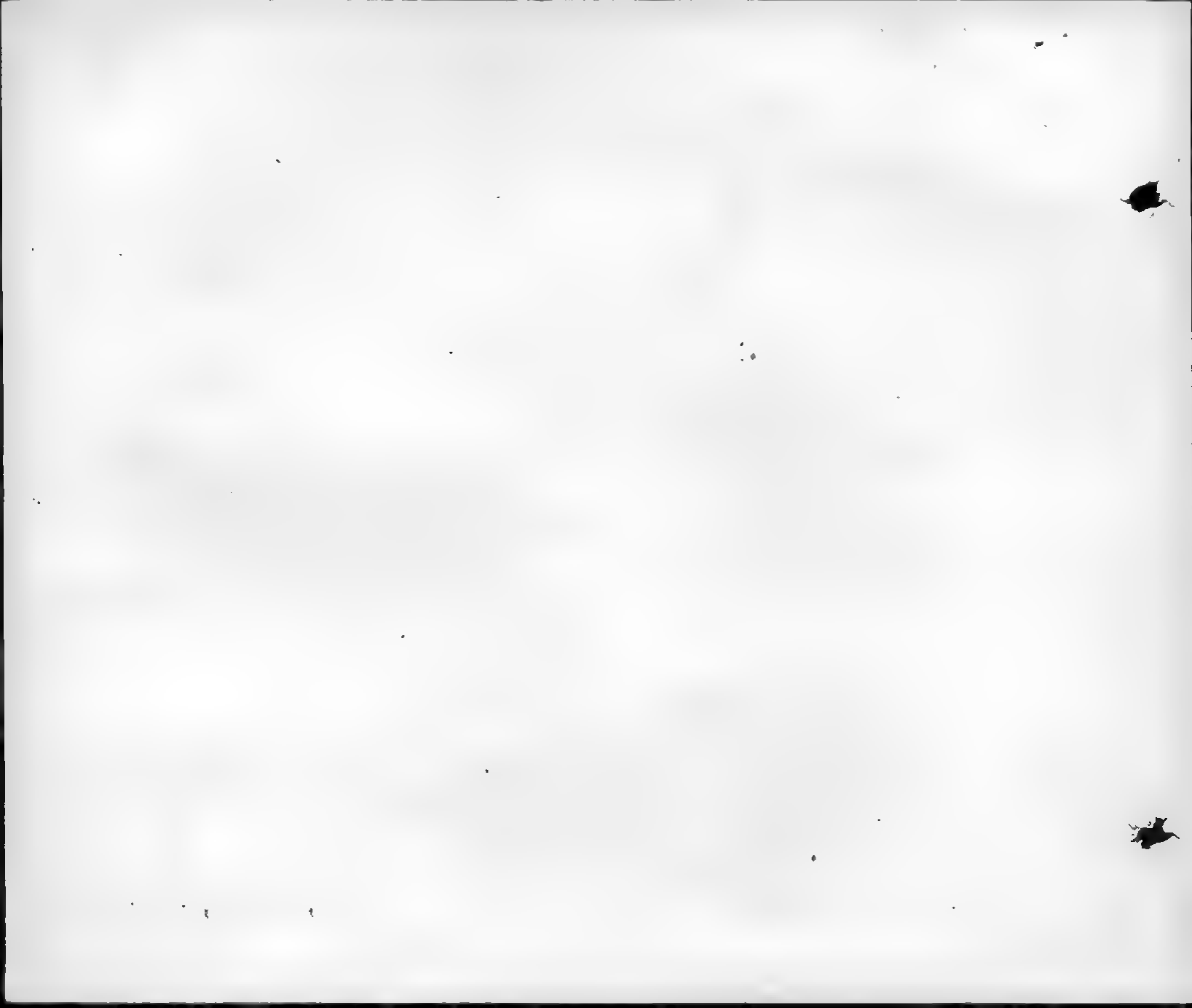
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>1980 Columbia Rd NW</u>			
3. NAME OF DECEASED (Type or print) <u>JOSE AGUILINO LASOÑEZ</u>				4. DATE OF DEATH <u>October 15 1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10 Aug 1891</u>	9. AGE (In years last birthday) <u>69</u> yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min	12. CITIZEN OF WHAT COUNTRY <u>Ecuador</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if ret red) <u>Ministry - (RET.)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Ministry - (RET.)</u>			
11. BIRTHPLACE (State or foreign country) <u>Ecuador</u>				12. CITIZEN OF WHAT COUNTRY <u>Ecuador</u>			
13. FATHER'S NAME <u>Lisardo LASOÑEZ</u>				14. MOTHER'S MAIDEN NAME <u>Avelinda NARANJO</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>70</u>			
17. INFORMANT <u>DAR+ LASOÑEZ (widow)</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Subdural hematoma left hemisphere</u> 936.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>936.9</u> DUE TO (c) <u>936.9</u>							INTERVAL BETWEEN ONSET AND DEATH <u>15 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Large subdural Thrombus Hypertensive Crani...</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 19.) <u>hypertensive stroke</u>			
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work Not while of work <input type="checkbox"/> <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>August 1960</u> to <u>Oct. 15 1960</u> that (I) <u>met</u> last saw the deceased alive on <u>Oct 15 1960</u> and that death occurred on <u>Oct 15 1960</u> from the causes and on the date stated above							
22a. SIGNATURE <u>Michel M. Healy</u> M.D.				22b. DATE SIGNED <u>10-15-60</u>			
22c. PHYSICIAN'S NAME (Type) <u>MICHEL M. HEALY</u>				22d. ADDRESS <u>WASHINGTON CLINIC WASHINGTON 15</u>			
23a. BURIAL CREMATION, RITUAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
<u>BURIAL</u>		<u>10/16/1960</u>				<u>QUITO, ECUADOR, SOUTH AMERICA</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Kavalero Sosa</u>				ADDRESS <u>1756 Pa. Ave. Wash. D.C. N.W.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 18 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>			

074

1

3

1

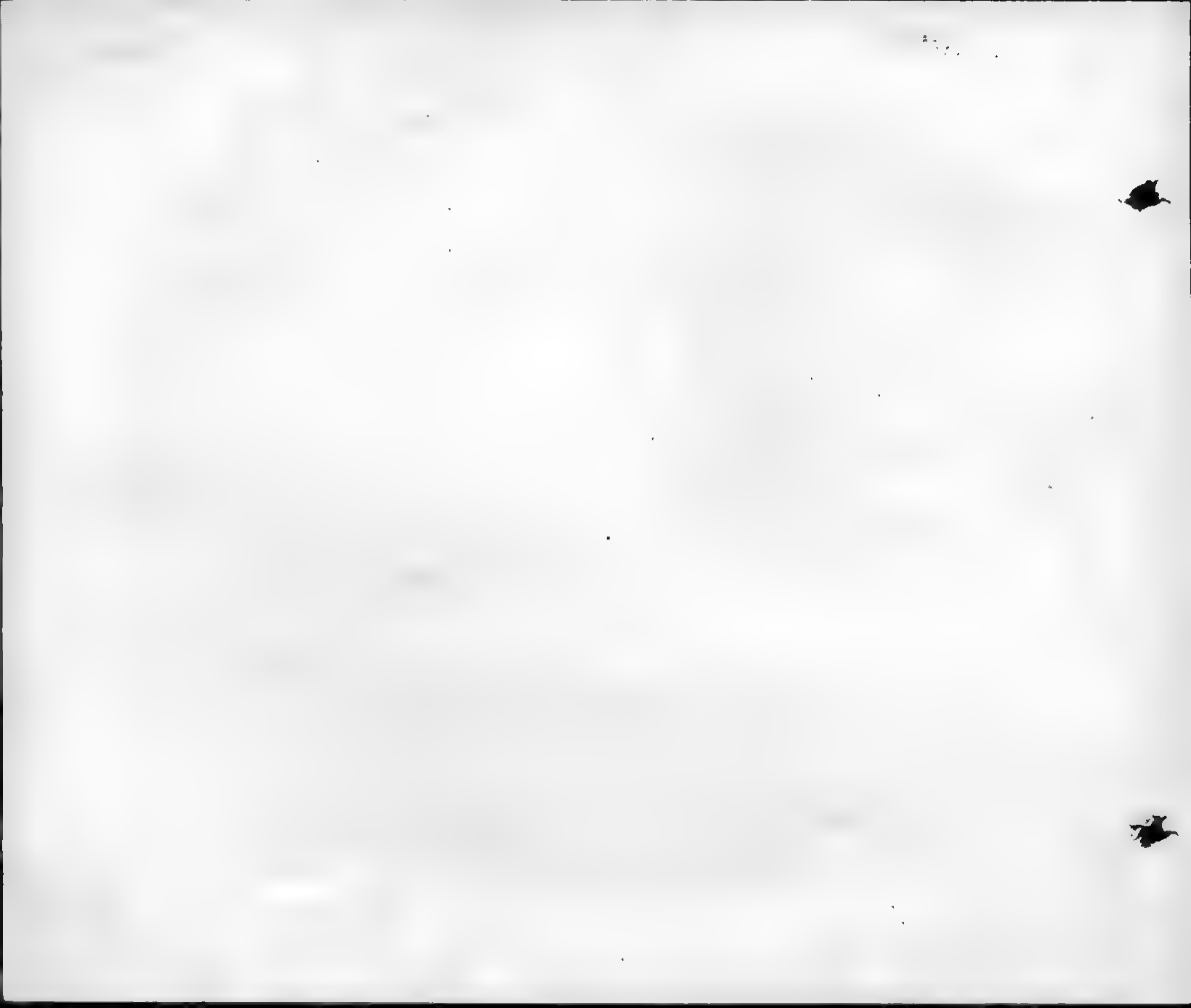


TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and any event within 72 hours after death.

1
11665
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11641

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>the good</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>8 M</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation Inc</u>				e. STREET ADDRESS <u>1416 Great Oak Road</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Nora Eugenia Walters</u>				4. DATE OF DEATH Month Day Year <u>Oct 14 1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 3, 1877</u>	9. AGE (In years last birthday) <u>82</u> yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>La Home</u>		11. BIRTHPLACE (State or foreign country) <u>Littleton, CO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Geo. W. House</u>				14. MOTHER'S MAIDEN NAME <u>Mary Telle</u> Phone <u>Gu 8-4263</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>A. E. Holmes</u> Address <u>Cism... #2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema - secondary to</u> 450.8 DUE TO <u>Labar Pneumonia + Pulmonary</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Sen. art. Sclerotic Heart + Semely</u>							INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>8 days</u> <u>5 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a m p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>16 Feb 1960</u> to <u>14 Oct 1960</u> that (I) (we) last saw the deceased alive on <u>14 Oct 1960</u> and that death occurred at <u>12 PM</u> from the causes and on the date stated above							
22a. SIGNATURE <u>John Bosley Ziegler</u> M.D.				22b. DATE SIGNED <u>14 Oct 1960</u>			
22c. PHYSICIAN'S NAME (Type) <u>JOHN BOSLEY ZIEGLER</u>				22d. ADDRESS <u>OLNEY, MD.</u>			
23a. BURIAL, CREMATION REMOVAL (Specify)	23b. DATE THEREOF <u>Oct 17 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Northwood Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Montgomery County, MD.</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur D. ...</u> ADDRESS <u>254 ...</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 17 '60</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>		



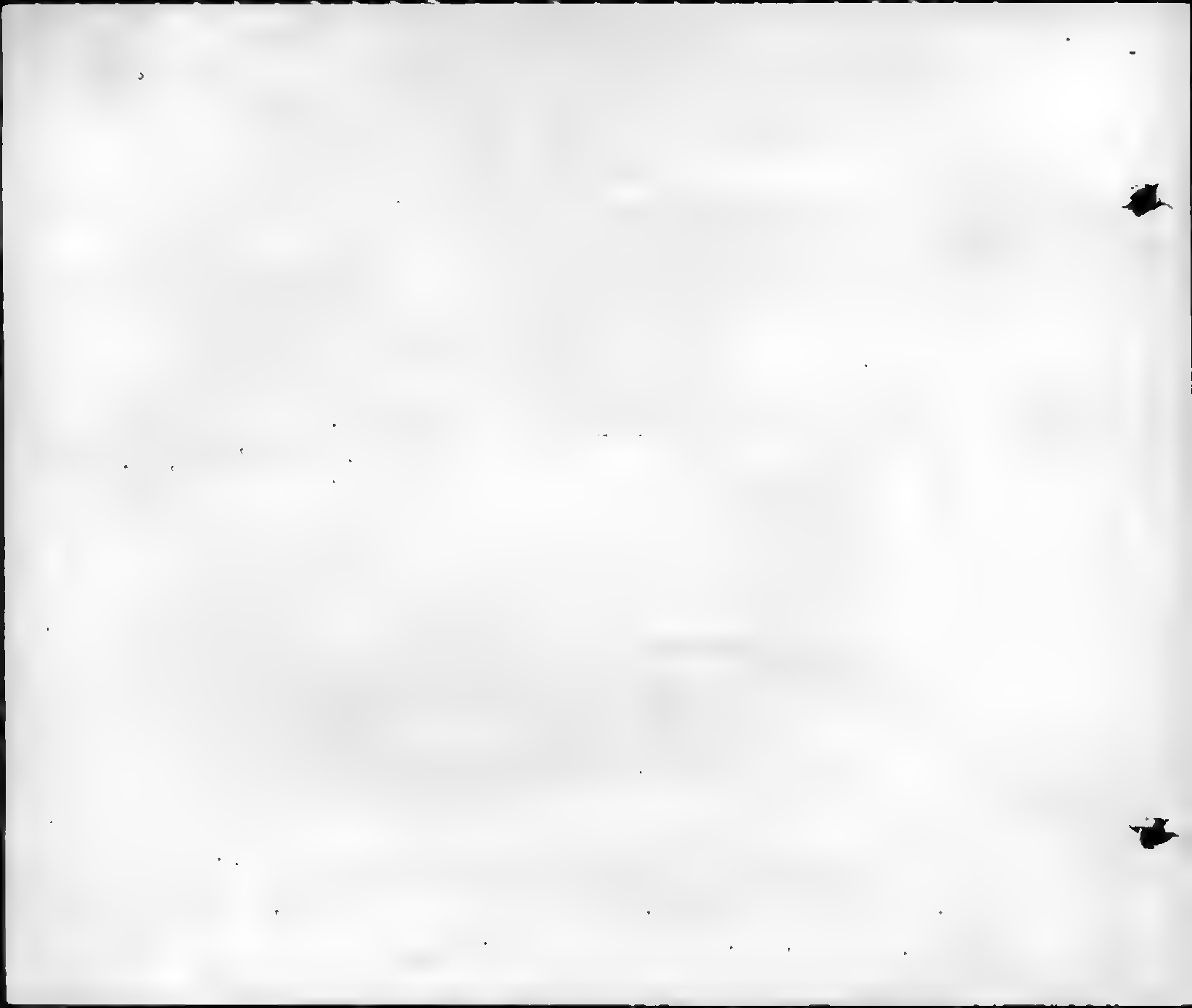
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11517

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11642

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>13 mo</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10402 Hemley Lane</u>				e. STREET ADDRESS <u>110402 Hemley La.</u>			
3. NAME OF DECEASED (Type or print) First <u>Gustav</u> Middle <u>Henry</u> Last <u>Weinel</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>25</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 1 1894</u>	9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Chicago City Govt</u>		11. BIRTHPLACE (State or foreign country) <u>Chicago Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Gustav Weinell</u>			14. MOTHER'S MAIDEN NAME <u>Fredericka Schmidt</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>319-26-2785</u>		17. INFORMANT <u>Martha M. Weinell</u>			
				Address <u>10402 Hemley Lane Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchial Asthma</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>5 yrs</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 1959</u> to <u>Oct 24 1960</u> , that (I) (we) last saw the deceased alive on <u>Oct 24 1960</u> , and that death occurred <u>8:25 AM</u> , from the causes and on the date stated above							
22a. SIGNATURE <u>John Lawrence Avery</u>		M. D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>Oct 25 1960</u>			
22c. PHYSICIAN'S NAME (Type) <u>John L. AVERY</u>		22d. ADDRESS <u>10110 Georgia Ave., Silver Spring, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. & BURIAL</u>		23b. DATE THEREOF <u>10/29/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MEM. PARK CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>EVANSTON, ILLINOIS</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u>				ADDRESS <u>SILVER SPRING, MD.</u>		25a. REC'D BY REGISTRAR <u>Oct 28 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>C. L. S. Thomas</u>			



1
FOR STATE
HEALTH DEPT.

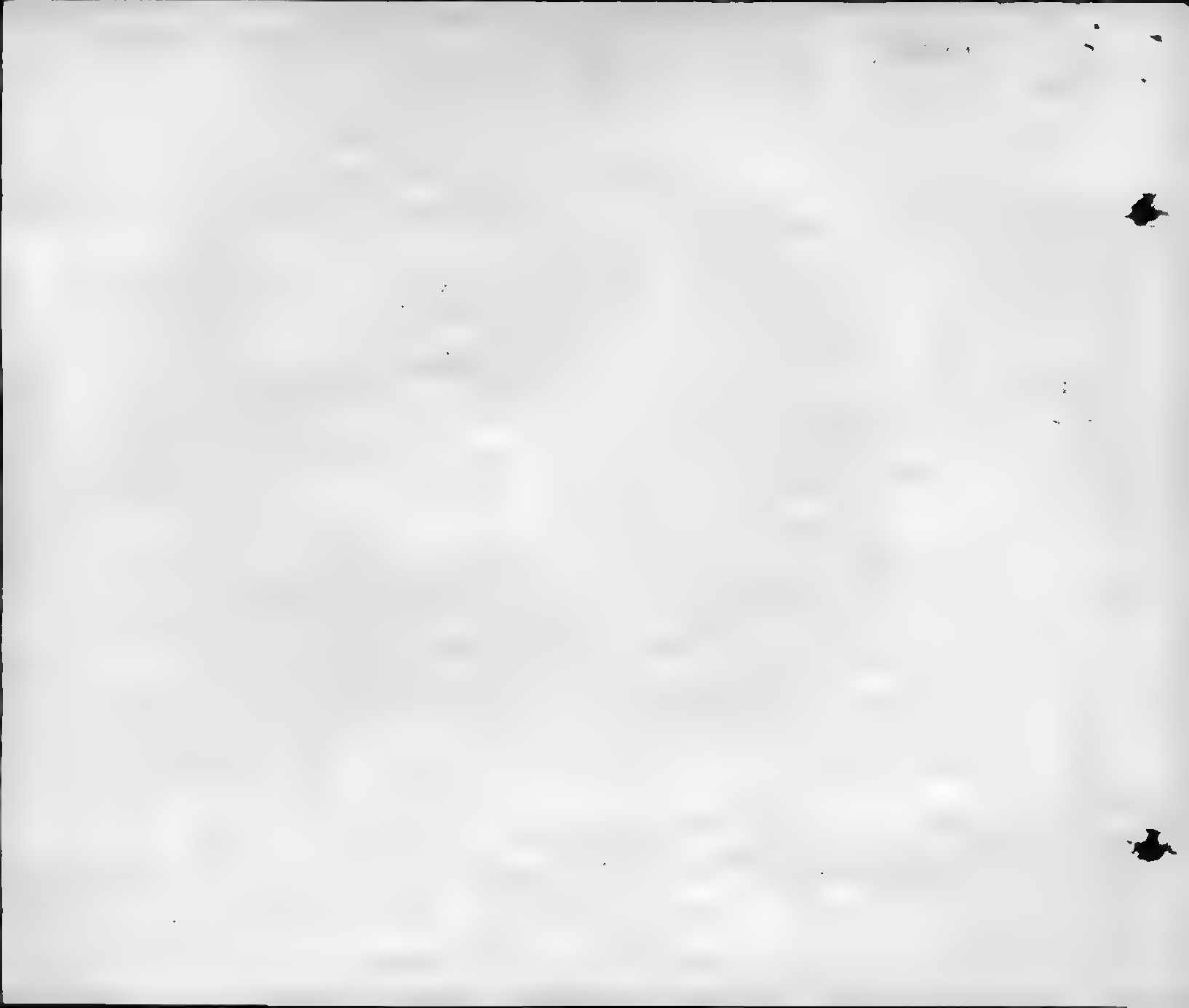
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME
SM 7/59

11560
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
11643

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Rockville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>248 Monroe st</u>				d. STREET ADDRESS <u>1208 Monroe st</u>			
3. NAME OF DECEASED (Type or print) <u>Henry West Wilson</u>				4. DATE OF DEATH <u>Oct 27 1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-13-1884</u>	
9. AGE (in years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Post office Dept - retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>W. DC</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>			
13. FATHER'S NAME <u>Isaac Wilson</u>				14. MOTHER'S MAIDEN NAME <u>Mary Bohren</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Catherine Wilson (wife)</u>				Address <u>Stuen 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Interval between onset and death</u> <u>Found dead in yard</u> (c) <u>Found dead in yard</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>9</u> a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>10/29/60</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>				22d. LOCATION (City, town, or country) (State) <u>Washington, D.C.</u>			
23. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>				24a. REC'D BY REGISTRAR <u>Oct 31 '60</u>			
ADDRESS <u>131 E. Monte Ave. Rockville, Maryland</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MEDICAL CERTIFICATION



1
2
11666
11644

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chen & Chase</u> 54	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Resnorson Hospital</u>		d. STREET ADDRESS <u>3907 LeLand Street</u> 1	
3. NAME OF DECEASED (Type or print) <u>Etta</u> First <u>D.</u> Middle <u>Worlberg</u> Last		4. DATE OF DEATH <u>Oct.</u> 9 19 <u>60</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/3/1890</u>
9. AGE (In years last birthday) <u>70</u> yrs		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Florida</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Abraham Simon</u>		14. MOTHER'S MAIDEN NAME <u>Ricky Stein</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Emma Morse</u> Address <u>Silver Spring Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Abdominal carcinoma -</u> <u>155-8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Cancer of the colon</u> DUE TO (c) <u>1 1/2 years</u> INTERVAL BETWEEN ONSET AND DEATH.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NO.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept/13, 1960</u> to <u>Oct/9, 1960</u> that (I) (we) last saw the deceased alive on <u>Oct/4, 1960</u> and that death occurred at <u>10:30 AM</u> from the causes and on the date stated above			
22a. SIGNATURE <u>Antonio Canadas</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>ANTONIO CANADAS, MD.</u>		22d. ADDRESS <u>1835 Pipe St N.W.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Oct 16, 1960</u>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <u>Washington Hebrew</u>		23d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>13 Danyandy & Sons</u>		25a. REC'D BY REGISTRAR <u>6501-H-424</u> DATE <u>OCT 11 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur J. Kane</u>			



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

11667

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

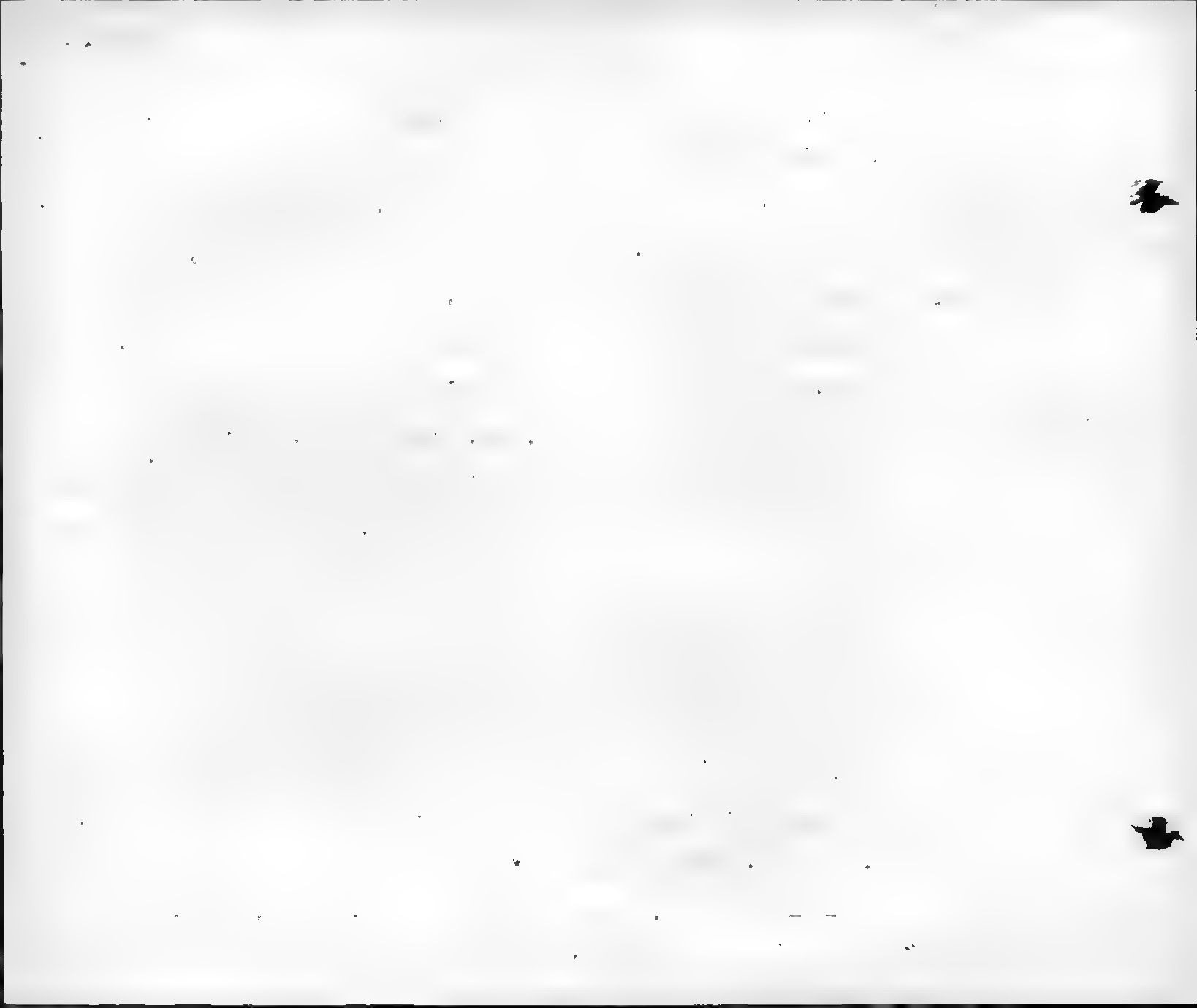
11645

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Poolsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Partnership Rest Home				d. STREET ADDRESS 113 A. West Third Street			
3. NAME OF DECEASED (Type or print) First Emily Middle Maude Last Wood				4. DATE OF DEATH Month October Day 24 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 22, 1874	9. AGE (In years last birthday) 86 yrs	IF UNDER 1 YEAR Months 10 Days 10 Hours 10 Min	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Store Clerk		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph H. Trundle				14. MOTHER'S MAIDEN NAME Emily Thomas			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yet, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO None		INFORMANT Address Mrs. E.O. Gardner 207 S. Washington St. Rockville, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-Vascular Accident, Right 331X DUE TO Cerebral Arteriosclerosis, (b) 10 minutes (c) 10 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 19 Hour o. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 29 Sept, 1960 to 24 Oct, 1960 , that I last saw the deceased alive on 24 Oct, 1960 , and that death occurred at 6:15 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Gordon M. Smith M.D.				ADDRESS (Street, city or town, state) Barnesville, Md DATE SIGNED 24 Oct 60			
PHYSICIAN'S NAME (Type) Dr. Gordon M. Smith M.D.				Barnesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-26-1960		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Kraus ADDRESS Frederick, Maryland				24a. REC'D BY REGISTRAR DATE OCT 26 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

(M)

(I)



TO HOSPITAL: 3. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Filed 10-20-60 et

CERTIFICATE OF DEATH

11556

Reg. Dist. No.

11646

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prin. Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chillum</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens Nursing Home</u>		d. STREET ADDRESS <u>1307 Legation Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Margaretha</u> First Middle Last		4. DATE OF DEATH <u>Oct 15 1960</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-1-71</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	9. AGE (In years last birthday) <u>89</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Halfpap</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Marion Brookbank</u>		Address <u>2813 Nicholson St</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral arteriosclerosis</u> <u>334X</u> DUE TO (b) <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic bronchitis and chronic bronchiectasis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 29, 1955</u> , to <u>Oct 15, 1960</u> , that I last saw the deceased alive on <u>Jan 7, 1960</u> , and that death occurred at <u>one a.m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walter K. Angerine</u> M.D.		ADDRESS (Street, city or town, state) <u>6300-13th St. NW, Wash. D.C. 20015</u>	
PHYSICIAN'S NAME (Type) <u>Walter K Angerine</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-17-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Addison Chapel</u>	22d. LOCATION (City, town, or county) (State) <u>Seat Pleasant Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>David Funeral Home</u>		24a. REC'D BY REGISTRAR <u>4812 Ga. Ave. NW</u> DATE <u>OCT 21 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Finner</u>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

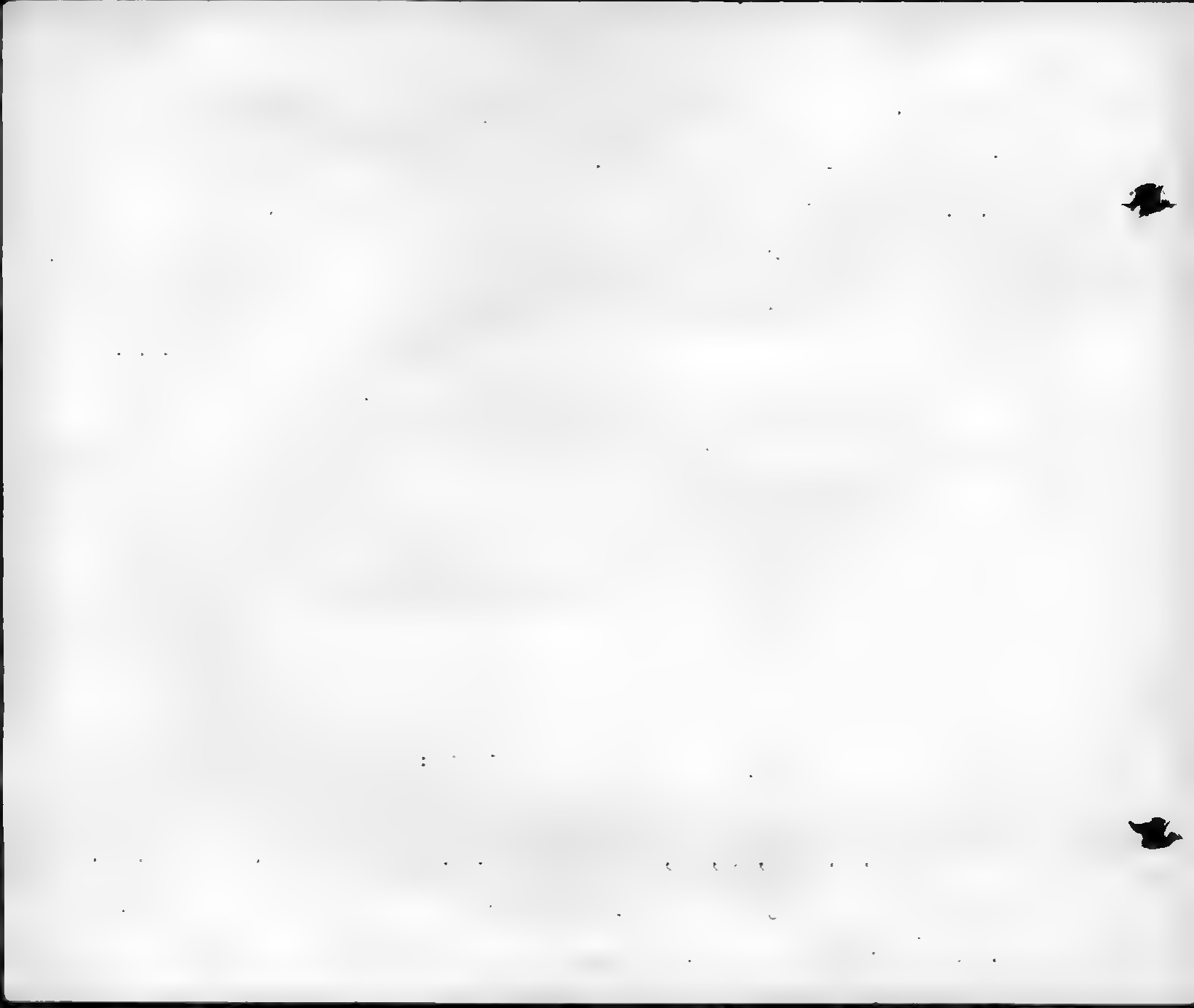
M

I

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND														
11668														
11647														
CERTIFICATE OF DEATH														
1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 51 mins. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital					2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park d. STREET ADDRESS 6908 Westmoreland Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last Martin Alan WORTHING					4. DATE OF DEATH Month Day Year October 11 19 60									
5 SEX Male		6. COLOR OR RACE Caucasian		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 10-11-60		9 AGE (In years last birthday) 51						
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.								
13. FATHER'S NAME Daniel James WORTHING					14. MOTHER'S MAIDEN NAME Marguerite Marie PINARD									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO None					17 INFORMANT (F) Daniel J. Worthing, same as #2 above Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) FETAL ATELECTASIS 782.5 DUE TO Conditions if any which gave rise to immediate cause (a), stating the underlying cause last. (b) IMMATURITY DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 51 min.										PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21 I certify that (I) physician attended the deceased from Oct. 11 8:39AM to Oct. 11 19 60 , that (I) xx last saw the deceased alive on Oct. 11 19 60 , and that death occurred at M , from the causes and on the date stated above.														
22a SIGNATURE R. V. Rack					22b. ADDRESS U. S. Naval Hospital, Bethesda, Md.									
22c PHYSICIAN'S NAME (Type) R. V. RACK, LT, MC, USN					22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.									
23a BURIAL CREMATION REMOVAL (Specify) Burial-Shipment			23b DATE THEREOF 10-13-60		23c NAME OF CEMETERY OR CREMATORY St. Sylvester's			23d LOCATION (City town, or county) (State) Graniteville Vermont						
24 FUNERAL DIRECTOR'S SIGNATURE R. A. Humphrey					25a. REC'D BY REGISTRAR DATE OCT 14 '60									
25b. REGISTRAR'S SIGNATURE Arthur S. Kneiss														

R. A. Humphrey Funeral Home, Bethesda, Md.

20-261XVO



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any change is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

11669

1
MONTGOMERY STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11648

Items 11, 12 Film G273 10-26-60 at

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Shady Spring
c. LENGTH OF STAY IN 1b 5 wks
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Sharon Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission on
a. STATE md b. COUNTY Pg
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyatstown
d. STREET ADDRESS 816 Thurman Ave

3. NAME OF DECEASED (Type or print) Katie C Wright
4. DATE OF DEATH Oct 15 1960
5. SEX female 6. COLOR OR RACE white 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH 4-17-1873 9. AGE (in years last birthday) 87 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 10b. KIND OF BUSINESS OR INDUSTRY Nursing Home Records 11. BIRTHPLACE (State or foreign country) Washington, D. C. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Beek 14. MOTHER'S MAIDEN NAME Sarah Burroughs.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. no 17. INFORMANT Nursing Home Records Address no

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion
Conditions, if any, which gave rise to immediate cause (b) sudden
(a), stating the underlying cause last. DUE TO (c) sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) no

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) no

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) no 20f. (City or town) (County) (State)

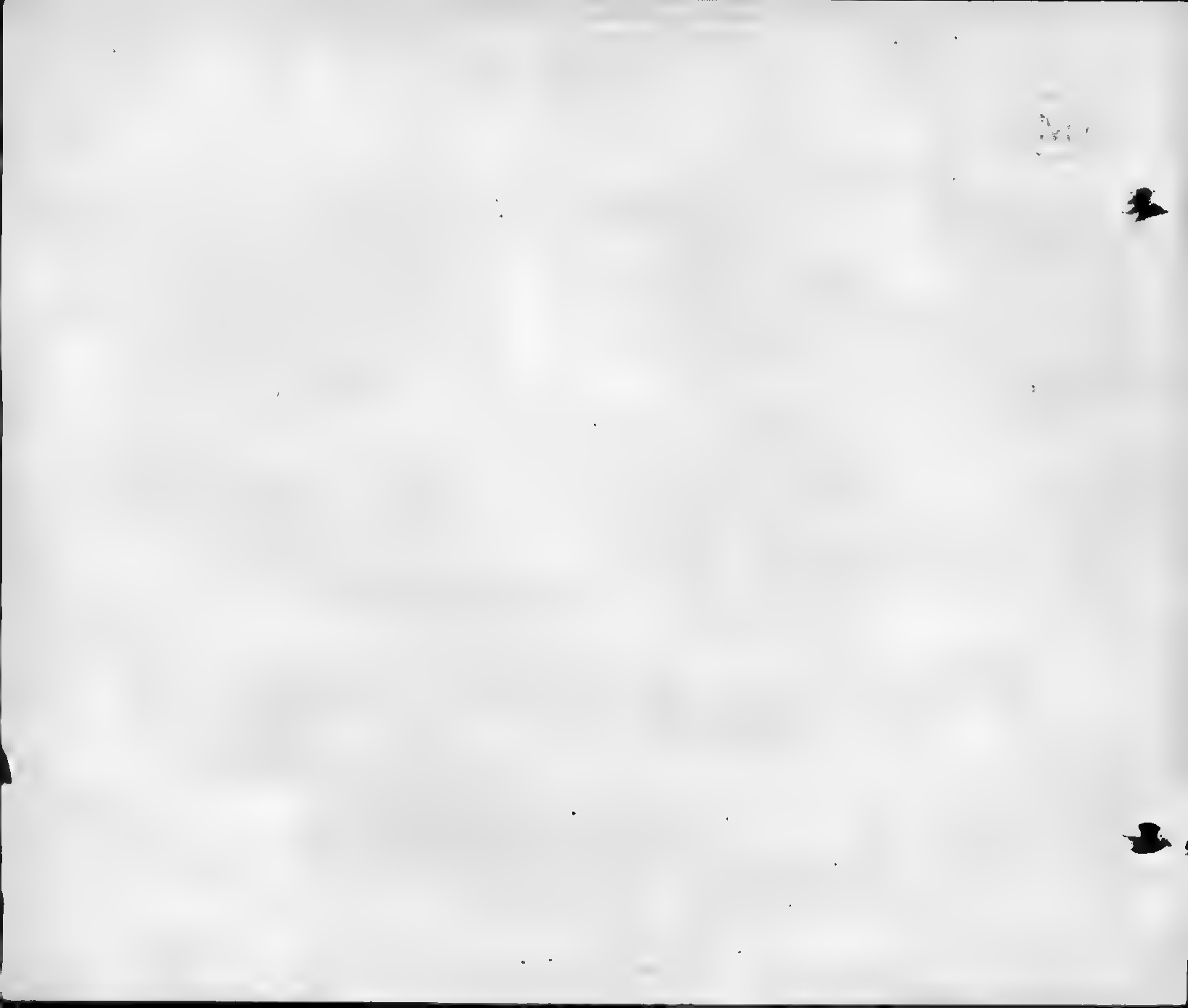
21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED 10-15-60

ACTUAL SIGNATURE Frank J. Broschaw M.D. EXAMINER'S NAME (Type) FLANK J. Broschaw Address (Street, city, town, or county) Suitland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 10-18-60 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill 22d. LOCATION (City, town, or country) (State) Suitland, Md.

23. FUNERAL DIRECTOR Lee Funeral Home - Washington D.C. ADDRESS no 24a. REC'D BY REGISTRAR no 24b. REGISTRAR'S SIGNATURE Arthur L. House DATE OCT 18 '60



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Monty</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brookville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brookville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Etchison - Monty Rd</u>		d. STREET ADDRESS <u>Etchison - Monty Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Lewis Henry Yinger Jr</u>		4. DATE OF DEATH <u>Oct 9 1960</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-10-1892</u>	
9. AGE (in years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Brushlayer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S &</u>	
13. FATHER'S NAME <u>Lewis H. Yinger</u>		14. MOTHER'S MAIDEN NAME <u>Helen M. Phoebe</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>W.W. 577-18-1426</u>	
17. INFORMANT <u>David C. Yinger - Brookville md</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>hemorrhage</u> DUE TO (b) <u>shot gun wound in mid-chest (heart)</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Self inflicted shot gun wound</u>	
20c. TIME OF INJURY Month, Day, Year <u>10-9-60</u> 10 a.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office building, etc.) <u>home</u>		20f. (City or town) <u>Brookville</u> (County) <u>Monty</u> (State) <u>md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschant</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-11-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		22d. LOCATION (City, town, or country) <u>Frederick, Md.</u> (State) <u> </u>	
23. FUNERAL DIRECTOR <u>Francis H. Barber</u>		ADDRESS <u>Laytons ville, Md.</u>	
24a. REC'D BY REGISTRAR <u>OCT 13 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knauss</u>	



1. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
11671 CERTIFICATE OF DEATH 11650									
Reg. Dist. No.									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Leesville</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Rockville</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Warrior Rest Home</u>					d. STREET ADDRESS <u>216 W. Montgomery Ave.</u>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>Clara Beble</u> First Middle Last					4. DATE OF DEATH <u>October 20</u> Month Day Year <u>1960</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>3/2/83</u>		9. AGE (In years last birthday) <u>77</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Harmon Winner</u>					14. MOTHER'S MAIDEN NAME <u>Unknown</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)					16. SOCIAL SECURITY NO <u>212-02-2985</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>331X</u> DUE TO <u>bleeding vascular accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO <u>generalized arteriosclerosis</u> (c) <u>hypertension</u>					INTERVAL BETWEEN ONSET AND DEATH <u>16 days</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Brown</u>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month. Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>Oct 17, 1960</u> to <u>Oct 20, 1960</u> that I last saw the deceased alive on <u>Oct 17, 1960</u> and that death occurred at <u>8:50 A.M.</u> from the causes and on the date stated above									
ACTUAL SIGNATURE <u>John S. Rogers</u> M.D.					ADDRESS (Street, city or town, state) <u>1919 Seminary Rd. Rockville, Md.</u> DATE SIGNED <u>10-20-60</u>				
PHYSICIAN'S NAME (Type) <u>John S. Rogers</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify)			22b. DATE THEREOF <u>10/22/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hygon Wecker</u> ADDRESS <u>1331 F. ...</u>					24a. REC'D BY REGISTRAR <u>OCT 24 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. ...</u>		

M

090

I



11672

CERTIFICATE OF DEATH

11651

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (If deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>P.G.</i> <i>4320 LAWRENCE ST.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda Md</i>		c. LENGTH OF STAY IN 1b <i>2 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Robine Nursing Home</i>		d. STREET ADDRESS <i>1644-2</i>	
3. NAME OF DECEASED (Type or print) <i>MARIE</i>		4. DATE OF DEATH Month <i>OCT</i> Day <i>13</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-24-1870</i>
9. AGE (In years last birthday) <i>90</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
11. BIRTHPLACE (State or foreign country) <i>GERMANY</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Jacob Demme</i>		14. MOTHER'S MAIDEN NAME <i>Minnie Eica</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Eleanor A. Jackson</i>		Address <i>Colmar Manor, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia -</i> <i>153-8</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>malnutrition</i> DUE TO (c) <i>Carcinoma of Colon -</i>			INTERVAL BETWEEN ONSET AND DEATH <i>4 days.</i> <i>6 mo.</i> <i>12 mo.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Generalized - Arterial Sclerosis -</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>3 Oct</i> , 1960, to <i>13 Oct</i> , 1960, that I last saw the deceased alive on <i>3 Oct</i> , 1960, and that death occurred at <i>2:05 AM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>John G. Ball</i>		M.D. <i>7936 Georgetown Rd -</i>	
PHYSICIAN'S NAME (Type) <i>John G. Ball</i>		<i>Bethesda 14 Med.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Transportation-10/13/60-</i>	22b. DATE THEREOF <i>10/13/60</i>	22c. NAME OF REMOVAL OR CREMATORY <i>Pittsburg</i>	22d. LOCATION (City, town, or county) (State) <i>Pennsylvania</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons Hyattsville Md.</i>		24a. REC'D BY REGISTRAR DATE <i>OCT 17 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1875

STATE OF OHIO

1875

IN SENATE,
January 13, 1875.
REPORT
OF THE
COMMISSIONER OF THE
LAND OFFICE,
IN RESPONSE TO A
RESOLUTION PASSED
BY THE SENATE,
MAY 12, 1874.
COLUMBUS:
PUBLISHED BY
THE STATE PRINTING OFFICE,
1875.

(1)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR ATS (4)
15M 9/59

1

MARYLAND DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
11673					11652				
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 14 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Triangle e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Cindy Middle Lee Last ZINK			4. DATE OF DEATH Month October Day 30 Year 1960						
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-14-60		9. AGE (In years fast birthday) yrs. 1 Months 16 Days IF UNDER 1 YEAR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----			10b. KIND OF BUSINESS OR INDUSTRY -----			11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Henry ZINK					14. MOTHER'S MAIDEN NAME Shirley Ann MAYO				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT Hospital Records		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) S gastroenteritis 571.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Viremia DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								INTERVAL BETWEEN ONSET AND DEATH 5 weeks 5 weeks	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that he (this hospital) attended the deceased from Oct. 16 19 60 to Oct. 30 19 60 , that he (we) last saw the deceased alive on Oct. 30 19 60 , and that death occurred at 3:30 PM from the causes and on the date stated above.									
22a. SIGNATURE L. G. Thorne					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 10-31-60		
22c. PHYSICIAN'S NAME (Type) L. G. THORNE, LT, MC, USN					22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 11-2-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia		
24. FUNERAL DIRECTOR'S SIGNATURE Everly-Wheatley Funeral Home, Alexandria, Va.					25a. REC'D BY REGISTRAR DATE NOV 2 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Huns		

9VVVVVVXVV

11057

11057

11057

11057

11057

11057

11057

11057

11057

11057

11057

11057

11057

11057

11057

11057

11057

11057

11057

11057

11057

11057

11057

11057

11057

11057

11057

11057

11057

11057

11057

11057

11057

11057

11057

11057

11057

11057

11057

11057

11057

11057

11057

11057

11057

11057

11057

11057

11057

11057

11057

11057

11057

11057

11057

11057

11057